Inefficiencies in DOD's Health Care Claims Processing: The Need to Improve Performance

THURSDAY, JUNE 22, 2000

HOUSE OF REPRESENTATIVES,
COMMITTEE ON THE BUDGET,
TASK FORCE ON DEFENSE AND INTERNATIONAL RELATIONS,
Washington, DC.

The Task Force met, pursuant to call, at 10:05 a.m. in room 210, Cannon House Office Building, Hon. Mac Thornberry (vice chairman of the Task Force) presiding.

Members present: Representatives Thornberry, Shays, Buyer, Moran, Spratt, and McDermott.

Mr. THORNBERRY. We are going to go ahead and get started. Mr. Moran is on his way and will join us shortly.

Let me welcome our witnesses and guests. This is the eighth in a series of hearings held by the Budget Committee to identify management and financial improvements to make government agencies more efficient and effective. Of course, making the most out of each taxpayer dollar is important to all of us and I certainly appreciate Chairman Kasich's focus on those issues.

Today, we are going to concentrate on improvements to the military health care system as part of an overall effort to improve quality of life for our military. Senior leadership at the Department of Defense and especially Chairman Shelton have committed themselves to making significant improvements in the TRICARE program. Unfortunately, the President's budget proposal this year did little to meet the full range of expectations which were created by the Chief's support.

George Washington once said that the willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional as to how they perceive the veterans of earlier wars were treated and appreciated by their nation, and that, in sum, is the heart of the reason this issue concerns me, not just doing right by retirees but how we can get and keep top-quality people in the military.

In May, the House passed a series of improvements in the Floyd Spence Defense Authorization Act to try to deal with a number of quality of life issues. Included in that was a 3.7 percent pay raise, adding money for housing allowance, dealing with the food stamp issue, and a number of improvements dealing with health care. I am pleased today that on our panel the chairman of the Personnel Subcommittee of the Armed Services Committee, the gentleman from Indiana, Mr. Buyer, has joined us, because he is responsible

for those improvements, as well as others which Congress has made over the past few years.

Among other things, we learned during Chairman Buyer's hearings that inefficient claims processing and payment were among the most significant factors undermining the provider and beneficiary support of TRICARE. We also found that substantial savings could be gained by reducing the cost of processing military medical claims. It is a disturbing fact that the average cost to process a Medicare claim is $1.78 while the average cost to process a TRICARE claim gets close to $8. There are a variety of reasons for those differences we will be talking about today, but the bottom line is, we could save up to about $500 million over the next 5 years if we can improve the paperwork and processing costs.

We are going to try to shed some light on the opportunities for those improvements and how managed care support contractors and DOD health officials can work together to reduce administrative requirements for TRICARE. I think the bottom line for all of us is that this money which is being used for administrative costs and paperwork could be used for health care, and that is certainly what we would prefer to have done.

At this time, I would yield to the chairman of this task force, the gentleman from Connecticut, for any statement he would like to make.

Mr. SHAYS. Thank you, Mr. Chairman. I also welcome our witnesses and guests.

Last year, I sat down with a squadron of F–15 pilots at Hurlbert Air Force Base in Florida and asked what was on their minds. I expected to hear about spare parts shortages, distress at their high operational tempo, and the need for fighter aircraft modernization. But the conversation that followed was dominated, I have to say overwhelmed, by complaints about the Department's health care program, TRICARE. They described difficulties making appointments, confusing coverage rules, delayed payments, and denied claims. They described anguished late-night telephone conversations with spouses and children calling from the other side of the world, pleading for help navigating the torturous TRICARE bureaucracy.

So when the task force vice chairman, Congressman Thornberry, suggested we focus our first hearing on inefficiencies in DOD health care, I concurred eagerly because wasted TRICARE dollars affect so much more than just the fiscal bottom line. Improving TRICARE claim processing and customer service improves the quality of life for millions of service members and their families. An efficient, responsive health care system contributes to military readiness and sustains morale. Military recruits need to be able to tell TRICARE success stories, not TRICARE horror stories.

When a prospective volunteer in today's competitive job market says, how is your health care plan, how is the DOD health plan, according to the General Accounting Office [GAO], TRICARE is too complex, but reluctant to standardize coverage rules for fear of further alienating an already diminishing pool of providers. The price of excess complexity is paid in scarce health care dollars as paper claims clog the system and fraudulent vendors manipulate the byzantine payment process to their advantage.

As the former chairman of an oversight subcommittee with jurisdiction over Federal health care programs, I am reluctant to cast the Medicare program as a role model of efficiency and responsiveness. In many ways, I think a comparison between claims processing costs in the two systems is apt, but TRICARE could emulate recent steps by the Medicare program to streamline claims through electronic processing, standardized vendor identification numbers, and systematically review high-risk claims for fraud. DOD should also evaluate the benefits of joint purchasing and closer integration with the Department of Veterans Affairs, VA, health programs.

I look forward to the testimony of our witnesses this morning on these important issues and also welcome our colleague, Mr. Buyer, who is clearly in the center of this issue, as well as Mr. Spratt, who has always been a constructive force on this Budget Committee.

Mr. THORNBERRY. I now recognize the distinguished ranking member of the full committee and member of the Armed Services Committee, the gentleman from South Carolina.

Mr. SPRATT. Thank you, Mr. Chairman, and thank you for convening this important hearing. I would like to welcome our three distinguished witnesses, Dr. Sears from the Department of Defense, Steve Backhus from the GAO, and William Meyer, Palmetto Government Benefits Administrator—a long name, but a very important company with a very, very impressive record of insuring stewardship in the management of our health care assets, both in Medicare and in TRICARE.

This particular hearing will focus on TRICARE, and I think that is extremely important. It is an important program that is not working as well as it should and must, and there are a number of problems with it and one is the cost of processing claims. The cost of processing claims for TRICARE exceeds the amount that we pay for Medicare and we need to know why. I think it has something to do with the implementation of the whole TRICARE program. I rather suspect that we have underestimated the cost of the TRICARE program providing the quality of care that our service members not only have a right to expect, they have earned the right to that kind of care.

And furthermore, as we have tried to in the Congress improve TRICARE, we have probably increased the burdens, the demands upon this particular system. If the House proposal which we have passed in the defense authorization bill goes through or if the Senate proposal goes through, for example, in the Senate, they are proposing that all retirees have the option once they are in TRICARE, TRICARE Prime, of staying in TRICARE Prime past the age of 65. I think they should have that right. I think they earned that right. But if that happens, that is nearly two million additional retired service members who will be imposing additional demands upon the system and we need to know, are we adequately providing for the administration of this system? Why does it cost so much to process these claims?

Mr. Meyer, I think you will tell the committee today that your organization at times has had its own substantial backup with the Department of Defense where you have processed numerous claims and had outstanding receivables for the payment of U.S. services that simply have not been paid in a timely fashion by the Depart-

ment of Defense. We need to get to the bottom of this if we are going to get to the bottom of the problems of TRICARE, and I think this is critically important.

I am delighted we are having this hearing. I have a much, much longer statement which I think is pertinent but I will not try the patience of the committee. Let us get on to the substance of it. Mr. Chairman, I would like to offer this for the record.

Mr. THORNBERRY. Without objection, any written statement members would like to make will be made a part of the record.

[The prepared statements of James Moran, Paul Ryan, and John Spratt follows:]

PREPARED STATEMENT OF HON. JAMES P. MORAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF VIRGINIA

Mr. Chairman, I want to thank you for scheduling today's hearing on TRICARE claims processing. I look forward to the testimony of our witnesses and greatly appreciate your willingness to allow me to submit my statement for the record.

As you know from my involvement on this Committee and on the Defense Appropriations Subcommittee, providing quality, affordable health care for our nation's military personnel, their families and retirees is an issue I have followed closely during my years in Congress.

It is especially important now as we grapple with difficulties in recruitment and retention of our military men and women. It is critical that this Congress not only provide adequate health care for our active duty personnel, but that we ensure that our nation's military retirees—especially the 1.4 million Medicare-eligible military retirees—have more health care options.

In the past few Congresses, I have introduced legislation granting Medicare eligible military retirees the option of participating in the Federal Employees Health Benefits Program. I introduced the Health Care Commitment Act because I am deeply concerned that military retirees, particularly once they become eligible for Medicare, are being denied access to health care. Medicare-eligible retirees are denied access to CHAMPUS. They are prohibited from participating in TRICARE. They are also effectively shut out of military medical treatment facilities because they are placed last on the priority list for receiving care.

In effect, we have created a system where military retirees, once they reach the point in life where they need health care the most, are given the least from their former employer. This does not happen in the private sector and does not happen to Federal civilian retirees. Having a large number of constituents who are military retirees, I am familiar with the enormous difficulties that many retirees experience in accessing affordable health care, especially at a time when they need it most.

I have worked with Congressman Spratt, Shows, Norwood and Cunningham, among others, on a variety of legislation aimed at providing better care for military retirees over age 65. The budget resolution offered by House Democrats was the first vehicle considered on the House floor this year to address this issue and include $16.3 bullion over 10 years to improve health care for Medicare-eligible military retirees.

While we could spend an entire hearing on health care options for our nation's military retirees, this hearing will concentrate on TRICARE claims processing.

In hearings held earlier this year by the Military Personnel Subcommittee of the House Armed Services Committee, there were several stories of unacceptable delays in TRICARE claims processing. In some of these cases, providers turned to the military beneficiary to seek payment for services rendered. This frustrates many service members and is a burden in particular for those that are deployed overseas. Even worse, as the service members tried to get TRICARE to pay and the bill went unpaid, the credit ratings of some service members suffered. So, prompt payment of claims is directly linked to quality of life and the morale of our troops.

While today's hearing will touch on the quality of claims processing, it will mostly focus on the cost of TRICARE claims processing. The Military Processing Subcommittee received testimony that the average cost of processing a TRICARE claim was between $8.00 and $15.00. Even the lower end of this range is substantially more than what it costs the Health Care Finance Administration to process Medicare claims.

It is my understanding that we will hear testimony today that the delays in claims processing occurred primarily in the mid-1990's when TRICARE was first

being established and that the most recent surveys indicate that TRICARE contractors are meeting or close to meeting the major deadlines for claims processing.

While I expect that witnesses today will also testify that many of the criticisms of TRICARE processing costs are inflated or based upon unfair comparisons to less complex claims, it is my hope that we can all agree that more can be done and commit to making TRICARE more user friendly and efficient.

Thank you for this opportunity to discuss such an important issue to our nation's 8.2 million active duty personnel, their dependents, and retirees. I look forward to hearing the testimony of our witnesses and any recommendations on how we can continue to improve the current system in order to achieve greater efficiencies and cost-savings.

PREPARED STATEMENT OF HON. PAUL RYAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WISCONSIN

Mr. Chairman, I would like to bring some inefficiencies of the TRICARE system to the attention of the members of the Task Force. Many of my constituents rely on TRICARE for their health care services—yet this program has repeatedly proven to be inefficient and ineffective, leaving my constituents and I with little recourse.

TRICARE is a regionally managed health care program for active duty and retired uniformed service members and their families. According to their website, TRICARE is being implemented as a way to: provide faster, more convenient access to civilian health care; create a more efficient way to receive health care; and control escalating costs.

In my experience with TRICARE, this has certainly not been the case. There have been a number of cases where I have assisted constituents who had problems with TRICARE, of which two took over 5 months to resolve.

The first case had over 20 claims submitted that were either paid incorrectly or not processed by TRICARE before the constituent contacted our office. When my office inquired as to why this was the case, TRICARE stated that clerical error was the cause of a number of the errors—for example, registering the health care expense as $10 instead of $100. TRICARE could not explain why the remaining claims were not processed.

Another case showing the inefficiencies of TRICARE included a situation where thousands of dollars in claims were processed incorrectly by TRICARE because Region 5 was not aware of changes in Federal law under the National Defense Authorization Act for FY '99. P.L. 105–261 was Federal law for more than a year prior to my inquiry. TRICARE repeatedly denied claims because of this—even during our inquiry.

These are just two examples of how the current TRICARE system has let down constituents in Southeastern Wisconsin. I have dealt with this program in countless other cases and I have found similar results.

I commend Chairman Shays and the Task Force for looking into this very real and pressing problem in our armed services today. Our military personnel deserve better health care than they are presently receiving and taxpayers should not be forced to pay for these inefficiencies.

Our service men and women should not have to wait 5 months to settle their health care claims. I look forward to working with you, Mr. Chairman and members of this Task Force, to put an end to this.

PREPARED STATEMENT OF HON. JOHN M. SPRATT, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF SOUTH CAROLINA

I want to thank you, Mr. Chairman, for convening this hearing, and welcome our three distinguished witnesses: Dr. James Sears, from the Department of Defense; Stephen Backhus, from the General Accounting Office; and William Meyer, of Palmetto GBA, from my own state of South Carolina.

This hearing is about one aspect of DOD health care, but I want to use this opportunity to make a larger point: we must provide better health care for military retirees once they reach age 65. I serve on both the Budget Committee and the Armed Services Committee, and I hear a lot about how military retirees are no longer encouraging young people to enlist. This red-hot economy is making recruitment and retention difficult enough. We do not need more disincentives to military service. General Henry Shelton, Chairman of the Joint Chiefs of Staff, agrees. He testified that guaranteeing lifetime health care is important not only to keep the promises made to those who dedicated their careers to military service, but also to attract and retain good people today. Providing health care to military retirees age 65 and over is an issue this Congress should tackle this year.

Today's hearing is on TRICARE claims processing. TRICARE is the Department of Defense's health care system. It is called TRICARE because it offers three options; an HMO option, a preferred-provider option, and a fee-for-service option. TRICARE uses a network of civilian health care providers to complement the DOD's own hospitals and clinics to provide health care to active-duty personnel and their dependents, and eligible military retirees and their dependents.

Currently, TRICARE is not available to military retirees who are eligible for Medicare. So when military retirees turn age 65, they can no longer obtain TRICARE. Since the military has downsized and the population of military retirees has grown and is still growing, it is difficult for most retirees over age 65 to get treatment at military facilities, even on a "space-available" basis, which is the only health care option now open to them. These retirees spend much of their adult lives in the military health care system, and get to know the doctors at the base and in the network where they retire. Then they turn 65, and in most cases, they have to establish new relations with new doctors at an age when continuity of care is extremely important.

The budget resolution offered by House Democrats was the first vehicle considered on the House floor this year to address this issue. We included $16.3 billion over 10 years to improve health care for Medicare-eligible military retirees. In part because of the impetus of the Democratic budget, the House and Senate Defense Authorization bills both propose extending DOD health care to military retirees, but do so in different ways. The House bill proposes expanding Medicare Subvention, where Medicare reimburses DOD for providing health care to Medicare-eligible military retirees, much as it reimburses private sector health care providers. Rep. Gene Taylor offered this provision as an amendment on the House floor. The Senate bill would allow military retirees age 65 and older to stay enrolled in TRICARE.

TRICARE is the successor to Civilian Health and Medical Program of the Uniformed Services, or "CHAMPUS." It began in the mid-1990's, and frankly, it has had growing pains. One of the growing pains is claims processing. There have been stories of claims being held up for long stretches of time. In these cases, some providers have turned to the military beneficiary to seek payment for services rendered. This frustrates many service members, and if you are overseas on deployment, it can be a real headache to deal with. Even worse, as the service members tried to get TRICARE to pay and the bill went unpaid, the credit ratings of some service members suffered. So, prompt payment of claims is directly linked to quality of life, and when we have trouble recruiting and retaining our soldiers, sailors, airmen, and marines, this is important.

Today we will likely receive testimony that there have been improvements in the quality of claims processing, and so we will focus even more on costs. There have been allegations that TRICARE is inefficient in processing claims in comparison to Medicare. In truth, TRICARE claims do cost more to process. This hearing will explore why that is, and what steps can be taken to reduce the cost of TRICARE claims management.

This is important for several reasons. First, the less we have to spend on claims processing, the more we have to spend on health care. I am from South Carolina and I represent Shaw Air Force base. I can tell you that TRICARE has a hard time signing up providers in my state. If we had more money to offer, we could induce more providers into the TRICARE network. In addition, the more we can standardize forms to make them easier to process, and the better TRICARE is in making prompt payments, the more doctors we can attract. This will make life better for active duty troops, eligible military retirees, and the families of both. TRICARE processed 32 million claims in 1999; if we could save $2 per claim, we could have up to $64 million more to spend on improving the TRICARE networks, particularly in areas like South Carolina.

Second, we may end up adopting the Senate provision to open up TRICARE to military retirees age 65 and older, and their dependents. That would bring in about 1.4 million eligible beneficiarees into the TRICARE system, and with them, many more claims. We have to get TRICARE claims costs down and make that process more efficient if we open up TRICARE to all military retirees.

The hearing today is just one subset of the DOD health care issue, but it is an important one. While claims processing has not gotten the attention that the question of health care for military retirees has gotten, it is part of the equation. If we can reduce costs here, it frees up resources sorely needed for our active duty troops and our military retirees. I look forward to the testimony of our witnesses.

Mr. THORNBERRY. The chair would now recognize the distinguished ranking member on the task force, the gentleman from Virginia, Mr. Moran.

Mr. MORAN. Thank you very much, Mr. Thornberry. Nice to see you. I want to thank you for scheduling today's hearing, Mr. Shays, Mr. Thornberry, and thank you, Mr. Buyer, for being here, and, of course, our ranking member of the full Budget Committee, Mr. Spratt.

This is an important issue. There are few more important issues than providing quality, affordable health care for our nation's military personnel, their families, and retirees, because unless we do it, the quality of our military capability is going to suffer greatly. This is one of the biggest issues in terms of recruiting quality personnel.

It is especially important now as we grapple with difficulties in recruitment and retention because the viability of the TRICARE system is in question. I probably get more complaints about military health care and TRICARE and retirees' health care than anything else. Now, that may partly be a function of my district, but I suspect that it cannot be a unique problem. There are 1.4 million Medicare-eligible military retirees and the Congress's attempt to provide adequate health care for them that is accessible and affordable has been one of the more controversial issues we have had to deal with.

In the past few Congresses, I have introduced legislation granting Medicare-eligible military retirees the option of participating in the Federal Employees Health Benefits Plan. I introduced a Health Care Commitment Act because I was concerned the military retirees, once they become eligible for Medicare, are being denied access to health care, given the fact that they do not have CHAMPUS available to them any longer. They are prohibited from participating in TRICARE and they are effectively shut out of the military medical treatment facilities because they are on the very bottom of the priority list for receiving care.

In effect, we have created a system where military retirees, once they reach the point in life where they need health care the most, are given the least from their former employer. We are the only large employer that does not provide health care as a benefit to its employees, that is, the Department of Defense military personnel.

Having a large number of constituents who are military retirees, I can relate to their problems and I think it is something that we are ultimately going to fix, but it is going to cost a great deal of money. The bill that was most recently considered on the floor that was sponsored by Mr. Spratt, Mr. Shows, Congressmen Norwood and Cunningham, as well, would have cost $16 billion over 10 years.

We can spend an entire hearing on health care options for retirees, but this is going to be primarily on TRICARE claims processing. There have been unacceptable claims in the claims processing for TRICARE. It has frustrated many service members and it is a particular burden for those deployed overseas. Even worse, as the service members tried to get TRICARE to pay and the bill went unpaid, the credit rating of many service members suffered. So prompt payment of claims is directly linked to the quality of life and morale of our troops.

While today's hearing will touch on the quality of claims processing, it will also focus primarily on the cost of that processing. The

Military Personnel Subcommittee received testimony that the average cost of processing a TRICARE claim was between $8 and $15. Even the lower end of this range is substantially more than what it costs the Health Care Financing Administration, HCFA, to process Medicare claims.

It is my understanding that we are going to hear testimony today that the delay in claims processing occurred primarily in the mid-1990's, when TRICARE was first being established, and that the most recent surveys indicate that TRICARE contractors are meeting or close to meeting the major deadlines for claims processing. I suspect the witnesses are also going to testify that many of the criticisms of TRICARE processing costs are inflated or based upon unfair comparisons to less-complex claims.

I hope we can all agree that more can be done and that we will commit to making TRICARE more user friendly and efficient. It is as important an issue as there could be to the 8.2 million active duty personnel, their dependents, and retirees, and so I am glad we are having the hearing. With that, I will conclude my statement. Thank you, Mr. Chairman.

Mr. THORNBERRY. Thank you.

The chair recognizes the gentleman from Indiana, Chairman Buyer, for any comments you would like to make.

Mr. BUYER. Thank you, Mr. Chairman, for the courtesy extended by inviting me to participate with you and other members during the examination of the cost of TRICARE claims processing. I also appreciate the kind remarks you extended to the Military Personnel Subcommittee of the House Armed Services Committee on the whole area of military health care benefits. There are very real and tangible benefits from the excellent bipartisan working relationship Mr. Abercrombie and I enjoy.

With regard to comments by the ranking member, Mr. Moran, he is very accurate in describing the 1.4 million retirees. We have to be very careful, I would say, in our language about what occurred on the House floor with regard to Mr. Taylor's bill with Medicare subvention, because the reality is we only have so much limited space, we only double the number covered by the Medicare subvention program from 30,000 to 60,000. So there is this unreal expectation out there among the force that I am going to be deriving a very real benefit and it is not going to be there.

We are going to work through this one, though. That is the good story here. And Mr. Spratt's comment about moving toward what the Senate has done, the Warner provision of saying when you turn 65, you really sort of stay in the TRICARE that you have, I am moving toward my own personal belief, having worked on these issues now for 8 years, that I do not believe anything magically should happen to a soldier when they turn 65. Now, I know that there are some members who are really concerned that we did not have this vote on FEHBP. We need to be very careful about how we conduct our business here.

So, Mr. Spratt, I enjoyed your comments on that because I think that is probably where we will end up going. The more we telegraph to whoever the next administration is going to be that when we put our arms around this one, the key here is that in 2003 as we prepare for the 2004 budget, there is going to be a large bill

that could be $8 to $10 billion. So I enjoyed the gentleman's comments.

The defense health program represents over $17 billion of the Department of Defense budget. About $4.7 billion of that now purchases care in the private sector through the TRICARE program. Included in the cost of the private sector care is the cost of the claims processing, which is estimated at $270 million.

Mr. Chairman, despite the fact that we already spend $17 billion a year on the Defense health program, the program is by some estimates underfunded, so I would say, Mr. Spratt, you are completely accurate. The GAO, even though the DOD does not like to admit it, they are saying that it is by at least $6 billion over the next 5 years, so that is a stunning number.

As a matter of fact, I want to share this with the Budget Committee, and this is completely another hearing. I believe that there is a problem in the modeling that the Department of Defense uses for the estimates of what their budgets should be. We have told them that year after year, but we still have those problems. So I just wanted to bring that to your attention.

We need to invest our resources in purchasing benefits, not unnecessary administrative costs. We should also ensure that savings we achieve should be plowed back into this chronically underfunded program. The TRICARE claims processing system has lagged behind the health insurance industry. It frustrates our TRICARE contractors. It also lags behind Medicare in moving to more efficient claims processing, as all of you have said in your statements.

I had directed that copies of several white papers that I have requested from not only the TRICARE managed support contractors but also that of the director of the TRICARE management activity, who we will be receiving testimony here today, were made available to the committee. These papers describe the faltering claims process that is in great need of modernization. In fact, our analysis indicated we might be wasting over $100 million a year as a result of the inefficient claims processing systems.

During our hearings on removing the barriers to TRICARE, we received testimony from TRICARE providers, claims processors, beneficiaries, managed care support contractors and the TRICARE management agency and lead agents. We learned in our hearings that there was a broad agreement among these different stakeholders that the system as it now exists is outdated and inefficient. Too many providers claim that they are not being paid in a reasonable period of time. The administrative requirements go far beyond what other governmental systems, like Medicare, require. As a result, far too many providers either never become participating providers or they end their active participation with TRICARE. The managed care support contractors have had to operate in a claims processing environment one of them has described during the committee hearing as "the best Model-T money can buy."

Mr. Chairman, we can do better and I think the Fiscal Year 2001 National Defense Authorization Act goes a long way in resolving some of these concerns. I will not use a lot of my time detailing all the specific actions that we have taken, but in summary, we directed several very specific actions to improve claims processing

and other business practice improvements to streamline and make user friendly all the TRICARE administrative systems.

One of the lessons we learned in the white papers is the cost per claim and chance for errors are increased whenever a claim is manually processed. The more these systems can be automated, the more efficient they become. As a result, costs and costly errors are reduced through the whole system. Therefore, most of our initiatives were designed to facilitate improving or expanding automated claims processing in TRICARE. You can imagine the example of a doctor who wants to track a particular claim. He actually speaks to a person, and the more that person handles it, the more time is invested and it just escalates the cost.

Mr. Chairman, the Fiscal Year 2001 National Defense Authorization Act, we picked much of what I would call the lower hanging fruit in our efforts to improve the TRICARE claims processing. However, I am confident that there are more opportunities for improvement, so I applaud the Budget Committee for choosing this as one of your subject areas to investigate.

Ferreting out waste or abuse wherever it can be found is wise. It is part of why we are here to serve, to make sure that we spend our limited resources in the right way and exercise good judgments to move toward good government principles. I appreciate the opportunity to participate in this hearing and look forward to continuing to exchange information with our witnesses we have here today, and let me extend compliments to them because I enjoy the working relationship which we have put together on the National Defense Authorization Act, and I yield back my time.

Mr. THORNBERRY. I thank the gentleman for his statements.

I trust the witnesses get a feel for the importance members place on the military health care system and some of the frustrations we feel if money is being used in a way that is not as efficient and not as it is intended to be used.

Without objection, each of you can submit written statements or whatever written materials you would like and they will be made part of the record.

We will first hear from the senior leadership of the Defense health program, Dr. James Sears, Executive Director of the Department of Defense TRICARE Management Activity. Then we will hear from Mr. Stephen Backhus, Director of Veterans' Affairs and Military Health Care Issues for the General Accounting Office. Then we will hear from Mr. William J. Meyer, Senior Vice President for TRICARE, Blue Cross-Blue Shield of South Carolina.

Dr. Sears, you may proceed.

STATEMENT OF H. JAMES T. SEARS, M.D., EXECUTIVE DIRECTOR, TRICARE MANAGEMENT ACTIVITY, DEPARTMENT OF DEFENSE

Dr. SEARS. Thank you, sir. Your concerns are ours.

Mr. Chairman, distinguished members of the task force, I appreciate the opportunity to be here today to discuss the Department's progress in improving claims processing, timeliness, and accuracy, while at the same time implementing initiatives to reduce the costs associated with adjudicating claims.

Before I address the issues, I want to acknowledge the support and positive working relationship we have with the House Armed Services Committee, with Mr. Buyer and his committee members, some of whom are on this task force. I also want to thank Representative Moran for his support as a member of the Defense Appropriations Committee.

Oftentimes, the cost of adjudicating TRICARE claims is compared to that of Medicare. Unfortunately, the two programs are not comparable entities. By definition, Medicare is a single fee-for-service program. TRICARE is a triple-option managed care program. Managed care, by definition, is designed to assure the efficient use of health care dollars. Ensuring this, however, requires the expenditure of administrative dollars. Perhaps an example will help.

We recently discovered in one of our regions a rate for caesarian sections that was six times the national average. Through the effective utilization management techniques, including preauthorization and retrospective clinical claims review, we have successfully changed practice patterns and improved the quality of care for this procedure in that region, while concurrently reducing health care costs by approximately 50 percent. This, however, minimally increased our administrative cost to conduct these clinical reviews.

On the other hand, our work simplification and claims reengineering initiatives revealed that the utilization management effort associated with prenatal ultrasounds associated with these deliveries were resulting in the verification that these procedures were, in fact, being delivered appropriately. This led to our elimination of the government requirement to clinically review ultrasounds and the savings of associated dollars.

Other differences between TRICARE and Medicare include the sheer number of citizens served by Medicare compared to the relatively small number of TRICARE beneficiaries. While Medicare processes nearly 900 million claims a year, TRICARE's 32 million claims annually do not provide the economies of scale Medicare enjoys. Our relatively small volume, especially as compared to Medicare, and far more comprehensive program inhibits our ability to dictate the business practices of the provider community.

The volume differences between TRICARE and Medicare also significantly impact our ability to achieve the same level of electronic submissions as Medicare. Our providers typically submit fewer than 10 TRICARE claims a month. Conversely, Medicare typically amounts for as much as 50 percent or more of a provider's income. There is simply no return on investment for small volume providers to invest in systems capable of submitting TRICARE claims when over 95 percent of our claims are paid within 30 days. Again, HIPAA, once implemented, will eliminate this issue and result in a dramatic increase in the receipt of electronic claims.

Over the last 2 years, the Department has been actively involved both independently and with the assistance of our contractors in reviewing the government's processes for adjudicating claims, with an eye toward balancing customer service with costs. These initiatives began with an effort we called work simplification. Through this process, the government partnered with our current contractors, who identified roadblocks to prompt and efficient claims processing. We identified a considerable number of impediments, in-

cluding mandated medical reviews, paper documentation, and other program complexities that inhibited the processing of claims.

We have issued two comprehensive changes as a result of this initial effort that remove the vast majority of these impediments and that, when fully implemented, will allow claims to adjudicate without human intervention. We used caution when implementing these initiatives. Each impediment to claims processing was weighed against the potential impact on health care dollar expenditures.

For example, removing medical review requirements and the requirement for the associated documentation subjects the government to excessive utilization and expenditure of finite health care dollars and the potential for fraud and abuse.

Conversely, our overemphasizing review processes increases the cost and time involved with processing of a claim. Working with our contractors, we are carefully reviewing every aspect of the health care financing and delivery system to determine where statistical sampling is more appropriate than individual case review, where case review is resulting in no savings, and where profiling will identify instances where the Department can focus on a very limited number of procedures or providers to ensure that health care dollars are not unnecessarily expended.

In conjunction with these efforts, the government is moving forward to implement the electronic submission of as many claims as possible. This is being done through the implementation of web-based technology and an emphasis on electronic claims submission, using Medicare's electronic submission requirements and encouraging our providers to submit their claims electronically in all of our education and marketing materials.

Electronic submission can gain us several benefits, equating to approximately $2 per claim. More importantly, electronic submission is a tremendous benefit to our providers in that simple clerical errors are detected immediately and corrected without delay. These electronic submissions also feed the provider's business systems to reduce the doctors' administrative costs.

From a claims processing perspective, these systems eliminate the need for our contractors to retype information. They eliminate keying errors. They substantially increase the number of "clean claims," and they allow claims to process in a fully electronic environment. While these substantial benefits accrue to the government, we also recognize savings in the area of filing and storage the vast amount of paper associated with manual claims processing.

Unfortunately, these efforts are not the panacea and we have much work left to be done before achieving a position where all provider-submitted claims are electronic. TRICARE alone has achieved an electronic submission rate that is nearing 50 percent. However, the Congress in legislating the Health Insurance Portability and Accountability Act, has provided the health insurance industry with the single most important tool for reaching our goal of 100 percent electronic claims submission. This tool is standardized format for the data elements and the transmission format will unify the entire industry and make the electronic submission of

claims the only practical business process available to the provider community.

We are looking forward to the publication of the HIPAA rules by HHS and the mandated effective date 2 years hence. In the interim, we are working very closely with our contractors and have implemented the first phase of web-based technology, These current systems allow our beneficiaries online access to their claims status and history. Each electronic web-based inquiry eliminates the need for a telephone call, including the associated staffing facility and infrastructure costs. We are rapidly expanding this technology and anticipate including physician access in the very near future as security and privacy issues are resolved.

As we are able to open these communication pipelines to all of our clients, our client satisfaction will increase while the government cost per claim will decline in future contracts.

Shifting gears, I would like to briefly address the issue that some of our beneficiaries are being pursued by collection agencies. While the number is extremely small, we are very concerned with each and every instance. All of our TRICARE contractors have established special units designed specifically to resolve collection issues. In addition, at each of our lead agents, we have created positions solely responsible for assisting our beneficiaries with whatever they require. We have expanded this function and created similar positions at each of our military treatment facilities to provide dedicated onsite assistance. I recognize that we can never guarantee that a single beneficiary will not be subject to collection. However, DOD is now in the position of being able to provide dedicated personal assistance and resolution to any problem that arises.

Finally, I wish to conclude with a word of caution. The key to reducing claims costs is to pay claims without human intervention. This is not without cost. We must carefully balance fully electronic claims payment with ensuring that taxpayer dollars are only expended for medically necessary and appropriate care, and as we progress in these efforts, claims costs will be reduced, but they will continue to contain those costs associated with ensuring the proper expenditure of government resources. We must also never forget service to our military men and women and the doctors who provide their care. This, too, is not without cost. However, the value of serving our beneficiaries cannot be understated.

I sincerely appreciate the time this task force has provided for me to briefly explain TRICARE claims and claim costs. I am at your disposal to expand on my comments and answer any other questions that you have.

Mr. THORNBERRY. Thank you, Dr. Sears.

[The prepared statement of H. James T. Sears, M.D., follows:]

PREPARED STATEMENT OF H. JAMES T. SEARS, M.D., EXECUTIVE DIRECTOR, TRICARE MANAGEMENT ACTIVITY

Mr. Chairman, distinguished members of the committee, I appreciate the opportunity to discuss the Department's progress processing TRICARE health care claims in the Military Health System.

My testimony today will focus on the steps we have taken to reduce the costs associated with processing TRICARE claims. First, I would like to report on two standards that have helped the Department make significant progress in claims processing timeliness.

Beginning in October 1999, TRICARE removed barriers to electronic claims submission and moved to claims processing timeliness standards similar to those used by Medicare. The new standards, effective October 1999, require our Managed Care Support Contractors to process 95 percent of accurately submitted claims within 30 calendar days from the date of receipt of the claim and payment errors may not exceed 2 percent. We have exceeded this standard in five of the last 7 months (in December 1999 and January 2000, 2 months where the standard was not met, the average was 94.4 percent). Our most recent information for March and April 2000, shows that our contractors exceeded the 95 percent standard by processing 97.5 percent of all accurately submitted claims within the 30-day standard.

The second standard requires contractors to process 100 percent of accurately submitted claims within 60 days of receipt. We continue to strive to meet this standard, however, for the most recent 2 months, we processed 99.6 percent of claims within 60 days. This extremely high level of performance will result in an ever-increasing number of satisfied providers who will submit more accurate claims either by mail or electronically. Accurate paper and electronic claims significantly reduce the manual intervention required in the adjudication process and equate to reductions in the overall cost of processing a claim.

These ongoing initiatives have resulted in dramatic increases in the prompt adjudication of claims mentioned previously and, as improvements continue to be realized, will result in further reductions in the cost of adjudicating TRICARE claims. We will continue our efforts to simplify requirements and reduce costs. When comparing our claim costs to those of Medicare, it is important to remember that there are significant differences between the two programs. Claim costs for TRICARE include a number of functions that are not included in Medicare claim costs. TRICARE claim costs include additional functions such as appeals, customer service, beneficiary and provider education, and coordination of benefits. In addition, for most Managed Care Support Contracts, the prime contractor uses the claims processing subcontractor's enrollment and utilization review systems, and those costs are reflected in the claim rate. There are also statutory requirements that increase complexity (and therefore cost). These include the three-tiered benefit structure for TRICARE (Prime, Extra, and Standard), differing copayments and catastrophic caps depending on rank or service status. They also include mandated special programs such as the Continued Health Care Benefits Program, TRICARE Senior Prime, and Base Realignment and Closure (BRAC) pharmacy benefits.

Further, while we expect that managed care will reduce health care costs overall, there are additional administrative tasks that accompany these reduced health care costs. These include the more extensive use of pre-authorizations and referrals that must be coordinated with claims. There is also significantly more effort in maintaining provider data. For example, the claims processor must track who is in the network and what the negotiated rate is for each service. This may vary even within provider groups or clinics, and network tracking and updates requires significant effort.

An example of managed care's impact on health care costs is the Pharmacy Data Transaction System (PDTS). The database will incorporate prescription data from retail networks, from the Department's National Mail Order Pharmacy program, and from pharmacies at Military Treatment Facilities. Each of these prescription sources will have an electronic connection to the national database.

PDTS will allow instantaneous checks for adverse drug reactions or duplicate prescriptions. It will also help prevent over-utilization and drug abuse by giving visibility of prescription drug usage across the Military Health System. The PDTS checks will occur at Point-of-Sale, allowing immediate patient intervention and education.

We expect to begin implementation of PDTS this summer, starting with the Managed Care Support Contractors' retail networks.

Over the past few months, the health care industry, like other industries, has been moving toward changing the way health care business is conducted. Health plans, providers, employers, health care consumers, and other health care-related businesses are adopting and applying new electronic technologies at great speed. Congress recognized the efficiencies and cost-savings that can be realized through electronic data interchange (EDI) and the application of standards in conducting health care business electronically, and passed the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The HIPAA statute requires the Secretary of Health and Human Services to adopt standards for financial and administrative transactions to enable health information to be exchanged electronically. These standards apply to the entire health care industry including the Military Health System. The first of these standards, those applying to electronic transactions and code sets, is expected to be published in a final rule in August, 2000. If published

as expected, the standards become effective in August 2002. The TRICARE Management Activity is committed to and actively working toward achieving full compliance with all HIPAA standards within the required time frames.

While the health care industry awaits the publication of the HIPAA standards and requirements, it is not waiting to develop and implement other e-commerce and web-based business applications and solutions. TRICARE isn't waiting either. The Department is actively reviewing all facets of its business practices and operations and is identifying those that can be moved to and performed on the Internet. Managed Care Support Contractors and their claims processing subcontractors are developing web sites on which beneficiaries and providers will be able to look up the status of their claims, submit enrollment applications, update addresses and other demographic data, submit health care questions, request authorizations and referrals, and conduct other health care related business. The Department has been working on the development of the electronic health care record with new versions of Defense Eligibility and Enrollment Reporting System (DEERS) and the Composite Health Care System (CHCS) which should ultimately allow for greater access by providers, beneficiaries, the Military Health System, and TRICARE business partners and contractors. The development of TRICARE data warehouses and of powerful data mining applications should provide DoD with valuable new health care information on which business decisions can be made and health care delivery improved for our beneficiaries.

The speed with which technology is evolving and being adopted by the health care industry requires that organizations evaluate and re-think how business is conducted. Health care consumers, our beneficiaries, are becoming computer-savvy and are demanding the kind of improved health care services that can be delivered today. The Department is actively working toward meeting their expectations and the expectations of the health care industry as a whole. The result of electronic commerce is the elimination of high cost human intervention which directly correlates to reduced claims processing costs.

The Department has developed TRICARE Encounter Data (TED) records to replace Health Care Service Records (HCSRs). These records are simply processed claims data that are submitted to TMA in a standardized format. The TED record has evolved from the Health Care Service Record (HCSR) to a more streamlined and "user friendly" format. Claims processors use proprietary systems for processing TRICARE claims. The outputs from these claims processing systems are in different formats and contain different data elements and values. The Military Health System needs a centralized database of processed claims and encounter data for financial and program management purposes. In order to centralize the data and incorporate it into a single database, it must come into the Department in a consistent format. The TED record prescribes a much easier standardized format for contractors to submit claims data that will further reduce administrative costs when adopted.

TED records allow us to apply rules and edits that help ensure that the claims and encounter data being submitted is accurate and reliable. Without the ability to establish rules and apply edits, financial and other important business decisions may be based on erroneous information with significant financial consequences.

As an alternative to TEDs, The Department is evaluating contractor proposals to eliminate TEDs altogether. Under this proposal, contractors would submit claims data to their own data warehouses to which they would allow DoD access. As part of our evaluation, we are looking at overall program costs to shifting from TEDs to a raw claims data-warehousing model.

For now, TED records should reduce costs over those previously associated with HCSRs and permit us to perform audits and monitor contractor performance. They can be used in bid price adjustment calculations and allow the development of reliable claims volume projections for procurements. They enable us to identify and recoup duplicate claims payments where one claim is paid by a contractor and the same claim is paid by another. They will continue to enable us to identify, account for and audit at-risk and not at-risk claims payments. Until a viable and even more cost-effective alternative emerges, TED records will support TRICARE management and provide better and easier access to claims data across the enterprise at reduced cost.

I am extremely pleased with the significant progress that has occurred over the last 2 years as a result of the joint efforts of the Managed Care Support Contractors, TMA, the Lead Agents, and the Surgeons General to reduce claims costs and complexities. Working together, we have removed thousands of Government specified claims reviews, such as the clinical review of oxygen, ultrasounds, and CT scans. We eliminated prescriptive controlled development requirements, simplified the provider certification process and now permit the use of commercial best practices for

utilization management. Soon, we plan to simplify requirements for coordination of benefits and for third party liability collections. By removing Government mandated reviews, we have not only complied with the President's acquisition reform initiatives, but have created a 21st century environment that allows our contractors to employ their best commercial practices to the processing of TRICARE claims while concurrently reducing cost.

These initial claims improvements were complemented by a study the Department commissioned by First Consulting Group (FCG). FCG applauded the work completed to date and offered additional suggestions for enhancements. These included allowing our contractors to accept the Medicare provider number on electronically submitted claims and assisting the Department and our partners in the utilization of new world wide web based technology. These initiatives, when fully implemented, will eliminate much of the need for human intervention, the highest single cost factor in claims adjudication.

Improving the TRICARE claims processing environment is a continuous quality improvement process. Our MCS contractors continue to submit suggestions for improving performance and implementing new technologies. Working together, with all of our partners, we will persist in our efforts to obtain state-of-the-art processes and systems that achieve the highest quality of performance at the most reasonable and effective cost to the Government.

Mr. THORNBERRY. Mr. Backhus, as I mentioned, your full statement will be made part of the record and you may proceed to summarize it.

STATEMENT OF STEPHEN P. BACKHUS, DIRECTOR, VETERANS' AFFAIRS AND MILITARY HEALTH CARE ISSUES, GENERAL ACCOUNTING OFFICE

Mr. BACKHUS. Thank you, Mr. Chairman. Good morning, Mr. Chairman and members of the task force. I am pleased to be here today to discuss what DOD can do to reduce TRICARE claims processing costs, and as you requested, I will also briefly discuss the need for increased anti-fraud efforts and more joint purchasing of pharmaceuticals and medical supplies with the VA, both of which could reduce costs. Finally, I will discuss our ongoing study of the process beneficiaries use to make medical appointments. The information I am presenting is based on a substantial body of work we have undertaken over the past several years on TRICARE operations.

Today, TRICARE has much room for improvement. Each claim costs an average of $7.50 to process, double the industry average and more than four times the $1.78 for Medicare claims processing costs. These higher costs are attributable to a number of factors.

Over half of TRICARE's claims are manually reviewed, a rate significantly higher than the industry average of 25 percent. For example, claims submitted for electrocardiograms require manual review, but in every case so far, after review, these claims have been paid. Last year, for one TRICARE contract alone, there were almost 14,000 of these claims.

Furthermore, claim inquiry rates average about one for every four-and-a-half claims, four times higher than Medicare inquiries. These inquires add substantial cost to the program.

But perhaps most significantly is that less than 20 percent of hospital and professional claims are submitted electronically, compared to the Medicare average of about 85 percent.

Obviously, we believe there is potential for reducing claims processing costs. The initiatives that DOD has underway and planned, some legislatively directed, if implemented properly, should go a long way toward reducing such costs. These include reducing man-

ual review requirements when they are unnecessary, promoting electronic claims submission, using automated voice response systems for provider inquiries, and adopting Medicare claims processing time limit standards. As a means of encouraging electronic claims submission, DOD is also permitting its contractors to delay payment of paper claims as long as overall time limit standards are met.

I need to caution, however, that the cost reductions from these and other efforts are limited and cannot be expected to approach current Medicare costs, primarily because TRICARE and Medicare are vastly different programs in terms of the benefit structure and size. For example, TRICARE's fixed costs are spread over a much smaller claims base than Medicare's and the TRICARE triple-option managed care benefit requires greater administrative costs than Medicare's fee-for-service plan.

I would now like to turn to opportunities for increased efficiencies in other TRICARE areas. DOD estimates that losses due to fraud and abuse could account for 10 to 20 percent of military health care expenditures. DOD could be more effective in combatting fraud and abuse if the contractors were more proactive in identifying and referring potential fraud cases. Out of over 40 million claims processed from January 1999 through April 2000, only 17 potential fraud referrals from contractors have been accepted by DOD for investigation.

DOD would also benefit financially through additional cooperative efforts with the VA to procure pharmaceuticals and through the use of VA's mail outpatient pharmacy for their refill workload. The expectation is that as the two agencies buy more of a particular drug, their leverage, particularly under competitively bid contracts, would permit them to obtain even greater discounts from drug manufacturers and save money for both departments. We believe that VA and DOD could potentially save between $150 to $300 million more each year by jointly purchasing medications. An additional $45 million could be saved annually if DOD used VA's mail outpatient pharmacy for their refills.

In addition to cost efficiencies, we are currently studying ways DOD could increase beneficiary satisfaction through changes to its medical appointment process. For years, beneficiaries have expressed frustration and confusion over how to access the health care system, largely because of the wide variability that existed in the appointment making process. Recently, DOD has been moving toward a centralized system that beneficiaries call to schedule all their appointments.

However, even this process appears to be confusing and frustrating to some beneficiaries because it is being implemented inconsistently. Some beneficiaries are transferred from the appointment center to a physician's office or clinic, some are told to call the office or clinic directly, and others get their appointments made as intended. Thus, what is meant to be a simplified, more user-friendly appointment process appears to still be a complex and confusing one, for beneficiaries are unsure who to call. We expect to be making recommendations at the conclusion of our work.

Mr. Chairman, this concludes my statement and I will be glad to answer any questions you or other members of the task force may have.

Mr. THORNBERRY. Thank you. I appreciate it.

[The prepared statement of Stephen P. Backhus follows:]

PREPARED STATEMENT OF STEPHEN P. BACKHUS, DIRECTOR, VETERANS' AFFAIRS AND MILITARY HEALTH CARE ISSUES, GENERAL ACCOUNTING OFFICE

Mr. Chairman and members of the Task Force, I am pleased to be here today to discuss opportunities to reduce claims processing and other costs of TRICARE—the Department of Defense's (DOD) managed health care program. Today more than 8.2 million active-duty personnel, retirees, and their dependents are eligible to receive care under this $16 billion-per-year health care system. As the costs of delivering health care continue to increase and as beneficiaries demand improved and expanded services, significant pressures have been placed on the system, and DOD continues to search for ways to address them.

Since TRICARE's inception, we have reported on the challenges DOD faces in delivering health care. DOD considers health care to be one of its major quality-of-life issues important to maintaining a quality force. As a result, DOD has continually striven to deliver this health care benefit and to respond to suggestions made for improving its health care system. Currently, DOD is facing increasing pressures to improve customer service. Improvements in areas such as claims processing not only have the potential to make the health care system more user-friendly and efficient, but also to reduce costs.

At your request, my testimony today will focus primarily on the cost of processing TRICARE claims. Additionally, I will briefly discuss two other opportunities that potentially can reduce costs and improve service to beneficiaries, namely increased antifraud efforts and more joint procurement of pharmaceuticals and medical supplies with the Department of Veterans Affairs (VA). You also asked that I discuss our ongoing study of the process beneficiaries use to make medical appointments. The information I am presenting is based on a substantial body of work we have undertaken over the past several years on TRICARE operations.

In summary, processing TRICARE claims costs several times as much as processing Medicare claims—$7.50 compared to $1.78 per claim on average. However, much of the cost difference appears to be attributable to differences in program design and processing requirements. For example, TRICARE offers three different benefit packages, with reimbursement rates that are established for each provider, and a complex system of authorizations and referrals. The program also experiences frequent changes to coverage and operating policies that make it difficult to administer. Nonetheless, we and others believe that opportunities exist to reduce some of the approximately $225 million spent annually to process claims. In response to the House version of the fiscal year 2001 Defense Authorization bill, and through several of its own initiatives that mirror private-sector practices, DOD has adopted and is planning several actions to reduce claims processing costs, including increasing electronic claims submission and web-based services to reduce the costs of claims review and to deal with the large number of inquiries received by providers and beneficiaries.

Beyond claims processing, we believe there are other opportunities to reduce TRICARE costs and improve services. For example, although DOD has efforts under way to combat health care fraud and abuse, these efforts have only been marginally effective. Additional opportunities exist to save potentially hundreds of millions of dollars that could be used to purchase care for military beneficiaries. Also, we believe that additional cooperation with the VA to procure pharmaceuticals and medical supplies could yield substantial savings. Lastly, different systems are in place throughout the military health system for making medical appointments, and beneficiaries sometimes are unsure as to how to make such appointments, leading to frustration with TRICARE. We are currently reviewing this process and anticipate making recommendations for improving it at the conclusion of our study.

BACKGROUND

DOD's primary medical mission is to maintain the health of active-duty service personnel and to provide health care during military operations. DOD also offers health care to non-active-duty beneficiaries, including dependents of active-duty personnel, military retirees, and dependents of retirees, if space and resources are available. The Army, Navy, and Air Force provide most of the system's care through their own medical centers, hospitals, and clinics, totaling about 580 treatment facili-

ties worldwide. Civilian providers supply the remaining care. TRICARE is a triple-option benefit program designed to give beneficiaries a choice among a health maintenance organization (TRICARE Prime), a preferred provider organization (TRICARE Extra), and a fee-for-service benefit (TRICARE Standard).

TRICARE is organized geographically into 11 health care regions administered by five managed-care support contractors. Among the contractors' many responsibilities are claims processing, for which all have subcontracted with one of two companies. DOD requires contractors to meet specific timeliness and accuracy standards when processing claims. The tasks required to process claims include claims receipt, data entry, claims adjudication, and claims payment or denial. During 1999, contractors processed about 30 million health claims submitted by institutions, health care providers, and beneficiaries.

To help safeguard against health care fraud and abuse in its system, DOD established a Program Integrity unit in 1982 to coordinate its antifraud activities. This unit is responsible for developing policies and procedures regarding the prevention and detection of TRICARE fraud and abuse. DOD's Office of Inspector General and the Department of Justice work together with this unit (and sometimes also with the Department of Health and Human Services) to investigate and prosecute alleged health care fraud and abuse. DOD's contracts with its five managed-care support contractors also require them to perform antifraud and abuse activities to help ensure that TRICARE dollars are used to pay only claims that are appropriate.

PROGRAM COMPLEXITY IMPEDES CLAIMS PROCESSING EFFICIENCY; IMPROVEMENTS UNDER WAY

Claims processing activities have generated a great deal of dissatisfaction among providers and beneficiaries, as well as among various congressional committees, and DOD recognizes that problems exist. Complaints and frustrations stem from perceived inaccurate and late payments; complex program rules, processes, and reporting requirements; and high costs. All agree that the claims adjudication system needs to be simplified and made more user-friendly, and that it could benefit from increased use of technology. A number of administrative and legislative actions are under way, which, if properly implemented, should reduce TRICARE claims processing costs.

PROGRAM COMPLEXITY AND SIZE CONTRIBUTE TO HIGH CLAIMS-PROCESSING COSTS

In August 1999, at the request of the House Subcommittee on Military Personnel, Committee on Armed Services, we reported on the complexity of the TRICARE program and benefit structure.[1] This complexity manifests itself in many aspects of claims processing such as high rates of manual review, low electronic submission rates, and high customer inquiry rates. These factors, in addition to the relatively small program size when compared with Medicare, increase TRICARE claims processing costs because fixed costs are spread over a smaller number of claims. Currently, TRICARE claims cost an average of $7.50 per claim to process—double the industry average and more than four times the $1.78 Medicare claims processing cost.

Contractors told us that of the many programs they administer, including Medicare and private plans, TRICARE is the most complicated, contributing to claims processing difficulties and high costs. For example, each of TRICARE's three options has a different array of benefits, copayments, and deductibles. Claims require different adjudication procedures, depending on which option is involved, and contractual requirements for prepayment review further complicate the process. Complexities such as these are manifested as thousands of edits in the adjudication logic of the claims processing system. These edits result in claims being "kicked out" of the system for manual review, which extends processing time and increases administrative costs. Over half of TRICARE's claims are manually reviewed, a rate significantly higher than the industry average of 25 percent.

Program complexities also contribute to numerous beneficiary and provider inquiries, which add considerably to the cost of processing a claim. TRICARE claim inquiry rates average about one for every 4.5 claims—four times higher than Medicare inquiries. Documentation shows that beneficiaries frequently inquire about their benefits and cost shares because they do not understand the program. Providers inquire most often about payment issues primarily because the same services might be reimbursed at different amounts depending on which TRICARE option the beneficiary is using. TRICARE has thousands of unique fee schedules and contracts

[1] Defense Health Care: Claims Processing Improvements are Under Way but Further Enhancements are Needed (GAO/HEHS–99–128, Aug. 23, 1999).

that change frequently. In contrast, Medicare reimbursement is more consistent because it has national standard physician and hospital payment methodologies. In addition, Medicare inquiries are handled almost entirely by automated systems.

TRICARE's per-claim processing costs are higher than Medicare's also because TRICARE's fixed costs are spread over a smaller claims base. Medicare costs are spread over about 900 million claims per year, whereas TRICARE processes only about 30 million claims per year.

Under TRICARE less than 20 percent of hospital and professional claims are submitted electronically, compared to the Medicare average of about 85 percent. Electronic claim submissions are faster, involve less chance of data input error, and are less expensive to process than paper claims. Paper-based claims require significant front-end handling in the mailroom, document preparation, imaging, data entry, and storage. However, because TRICARE is usually a small percentage of providers' income—often less than 5 percent—providers have no incentive to incur the expense of adapting their computer systems to permit electronic TRICARE claim submission. Furthermore, because 98 percent of claims are paid within timeliness standards, the incentive to submit electronic claims is further reduced.

Nevertheless, we believe that some opportunities exist to reduce the administrative costs associated with processing a TRICARE claim. One of the claims processing subcontractors reported that $4.46 of each claim processed—totaling about $125 million per year—is paid for services provided or processes required by the program above the costs of determining payment outcomes. For example, responding to TRICARE inquiries reportedly costs $1 per claim more than responding to Medicare inquiries. Other costs that we consider to be targets of opportunity include mailroom handling, document preparation, imaging, paper storage, data entry, and certain reporting requirements. A number of initiatives are currently under way or planned that may reduce these costs as described below.

INITIATIVES UNDER WAY TO IMPROVE CLAIMS PROCESSING EFFICIENCIES

Several legislatively directed and DOD-initiated efforts are under way to simplify the claims adjudication process, improve provider and beneficiary education, and increase electronic claims submission. If properly implemented, these actions should reduce TRICARE claims processing costs.

For example, the House version of the fiscal year 2001 Defense Authorization bill would direct that the Secretary of Defense take action to require high-volume TRICARE providers to submit claims electronically, and increase the use of automated voice response systems for provider inquiries on claims status. Also, the bill would direct that certain administrative reporting requirements be reduced.

With the assistance of a consultant, DOD has developed and is implementing a plan that calls for eliminating unnecessary or duplicative processes that interfere with optimal performance, emphasizing the use of commercial best practices and Medicare standards. For example, the plan calls for adopting Medicare's standards for processing timeliness and the elimination of DOD required edits that should help decrease the number of manually reviewed claims. According to one of the claims processing subcontractors, some of these edits are unnecessary while others should be modified or retained. For example, claims for electrocardiograms must be manually reviewed, but in every case so far, the claims have been paid after review. Last year, for one TRICARE contract, almost 14,000 claims for this procedure were submitted. While DOD has issued formal contract modifications for all the changes it wants to make, contractors have not yet had time to implement all of them.

Additionally, DOD is pursuing the possible use of Medicare's provider identification numbers to encourage and facilitate electronic claims submission. Also, DOD now permits contractors to delay the payment of paper claims (as an incentive for providers to submit electronically) so long as the contractors continue to meet standards. This initiative mirrors Medicare's process for increasing the number of claims submitted electronically. Further, to reduce the number of manual reviews, DOD is encouraging contractors to limit prepayment review of certain types of claims if appropriate.

DOD and the contractors are also looking at ways to use new technology on the World Wide Web to reduce administrative costs and increase provider and beneficiary satisfaction. Currently, TRICARE claims processing subcontractors have developed comprehensive Web sites containing information on policy and benefits, electronic claims submissions, and claim status.[2] In addition, DOD and contractor

[2] One subcontractor's Web site (*www.mytricare.com*) allows beneficiaries to access claim status while the other subcontractor's site (*www.wpsic.com*) gives providers access. Both sites are designed to ensure the privacy of beneficiary information.

officials are considering future use of the Internet as a means to submit claims for processing. This method, which is similar to that used for electronic claims, might provide a more expedient, less expensive means of handling claims. However, before this Web-based technology can be utilized, the government must define security requirements to ensure privacy.

Nonetheless, because TRICARE makes up such a small percentage of most providers' business, neither Web-based nor electronic claims submissions are likely to significantly increase in volume without specific incentives or mandates. However, mandates may increase providers' reluctance to participate in the program. In the future these problems may be mitigated as a result of industrywide requirements to adopt uniform standards for electronic health care transactions, including claims.[3] Uniform standards for electronic claim submissions will enable providers to submit claims for any health insurance plan in the same filing format.

DOD COULD SAVE HUNDREDS OF MILLIONS OF DOLLARS WITH A MORE EFFECTIVE ANTIFRAUD PROGRAM

While DOD does not know the precise extent of fraud and abuse in its health care system, it estimates potential annual losses to its TRICARE program to be in the hundreds of millions of dollars. In addition to the financial loss, health care fraud and abuse also affects the quality of care provided and may cause serious harm to patients' health. Despite its responsibility to prevent and detect health care fraud and abuse, DOD has not been effective in doing so, recovering less than 3 percent of its estimated losses to fraud and abuse between 1996 and 1998. DOD has the opportunity to improve its antifraud efforts by developing clear and measurable goals and ensuring that contractors comply with the antifraud requirements in their contracts.

DOD estimates that losses due to fraud and abuse could account for 10 to 20 percent of military health care expenditures. These ranges are consistent with estimates of other public and private-sector organizations, such as the Health Care Financing Administration, the U.S. Chamber of Commerce, the Health Insurance Association of America, and the National Health Care Anti-Fraud Association. Given TRICARE's expenditure of about $2.9 billion for contracted civilian-provided care in fiscal year 1999, DOD could be losing between $290 million and $580 million annually to fraud and abuse. DOD officials acknowledged that they could be more effective in combating fraud and abuse if their TRICARE contractors were more proactive in identifying and referring potential fraud cases. They also agreed that they should expedite the implementation of revised antifraud policies and requirements that place greater demands on contractors to identify and prevent fraud and abuse. However, although DOD provided contractors with antifraud software, not all contractors are using the software. Further, DOD required contractors to develop and submit antifraud plans, but most contractors' initial antifraud plans were deficient. Current statistics do not indicate any significant improvements in DOD's antifraud efforts. Out of over 40 million claims processed from January 1999 through April 2000, only 17 fraud referral cases from the contractors have been accepted by DOD for investigation.[4]

ADDITIONAL JOINT PROCUREMENT OF PHARMACEUTICALS WITH VA WOULD YIELD SUBSTANTIAL SAVINGS

We recently testified that DOD and VA would benefit through additional cooperative efforts to procure pharmaceuticals and through the use of VA's Consolidated Mail Outpatient Pharmacy (CMOP) for DOD's prescription refill workload.[5] As the largest direct Federal drug purchasers, the Departments already enjoy varying, though significant, discounts on their drug purchases. The expectation is that, as the two agencies buy more of a particular drug, their leverage—particularly under competitively bid contracts—would permit them to obtain even greater discounts from drug manufacturers and to save funds for both Departments. Currently, the two agencies have awarded 18 joint and 51 separate national contracts representing 19 percent of their combined drug expenditures of $2.4 billion in fiscal year 1999.

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[3] The Health Insurance Portability and Accountability Act of 1996 (P.L. 104–191) requires the industrywide adoption of uniform standards for electronic transactions, including claims filing.

[4] These 17 cases all involved high dollars or had the potential to cause patient harm. In addition, contractors submitted numerous small dollar cases that DOD has returned, believing they should be handled as overpayments rather than as fraud.

[5] DOD and VA Health Care: Jointly Buying and Mailing Out Pharmaceuticals Could Save Millions of Dollars (GAO/T–HEHS–00–121, May 25, 2000).

We believe that VA and DOD could potentially save $150 to $300 million more each year by jointly purchasing other medications they both use.

Further, additional savings could be achieved by utilizing VA's mail-out pharmacy program to handle DOD's annual refill workload of about 23 million prescriptions. For example, VA has the capability for mail order refills through its CMOP and documentation shows that CMOP refills cost about one-half of DOD's current costs of refilling prescriptions at military pharmacies. CMOPs potentially could reduce military pharmacy refill dispensing costs by about $45 million annually.

IMPROVING THE MEDICAL APPOINTMENT PROCESS WOULD LIKELY INCREASE BENEFICIARY SATISFACTION

Since the inception of TRICARE, beneficiaries have complained about the difficulties they encounter in making appointments for health care. For years beneficiaries seeking to make appointments in military treatment facilities accessed care by calling the desired clinic directly. Over the past several years however, DOD has been moving toward a centralized appointment system. In some military medical facilities an appointment center has been created and beneficiaries call that center to schedule various types of appointments. In four TRICARE regions though, TRICARE contractors have established regional appointment centers which beneficiaries call to schedule appointments with physicians in military medical facilities. The contractors perform this function as part of their administrative tasks under their contracts with DOD. We are currently reviewing the appointment making process in TRICARE.

We are finding that the lack of uniform appointment names and requirements for scheduling appointments has resulted in confusion for both appointment clerks and beneficiaries, with beneficiaries sometimes being transferred from the appointment center to the military clinic, or told to call the clinic themselves.

Thus, what is meant to be a simplified, more user-friendly appointment process appears to be a complex and confusing process, where beneficiaries are unsure as to whether to call the contractor or the military medical facility to schedule appointments. We expect to be making recommendations at the conclusion of our work.

Mr. Chairman, this concludes my prepared statement. I will be happy to answer questions you or other Task Force members may have.

Mr. THORNBERRY. Mr. Meyer, we will go ahead and let you proceed with your opening statement. We do have a vote, so members may be coming and going. I think it is just one vote, so we will try to keep things going as best we can. You may proceed.

STATEMENT OF WILLIAM J. MEYER, SENIOR VICE PRESIDENT OF TRICARE, BLUE CROSS-BLUE SHIELD OF SOUTH CAROLINA

Mr. MEYER. Thank you, Mr. Chairman, Congressman Shays, Congressman Moran, Congressman Thornberry, Congressman Spratt, Congressman Buyer. I thank you for the opportunity of inviting me here today and thank you for your interest in the experience of my company, Palmetto Government Benefit Administrators, a division of Blue Cross-Blue Shield of South Carolina.

I appreciate your concern with the difference in processing costs between Medicare and TRICARE and welcome the opportunity to give you some information and ideas based on our experience. Blue Cross-Blue Shield of South Carolina, through its subsidiaries, is the largest claims processor in the country for both Medicare and TRICARE, so we have a thorough understanding of the administrative cost structures and program differences of both programs.

The national average cost to process a Medicare claim in fiscal year 1999 was $1.78. The average cost to process a TRICARE claim at my company is just over $7.50. While on its face this is a large disparity, close analysis shows that there are reasons for it. The best way to understand the differences in these processing costs is to understand the differences between the two programs.

The most important difference is the most basic. By definition, Medicare is a fee-for-service program while TRICARE is a managed care program. The whole concept of managed care is that managing health care to maximize its efficiency will result in increased administrative cost, but that resulting efficiency will save far more than its cost. A complex system of authorizations, referrals, and discounted provider networks means that the same service might get paid for in dozens and even scores of different ways. This acknowledged administrative complexity is far different from what we find in Medicare, where fees are set, regardless of the provider, and almost every claim is paid the same way.

There is a propensity to look at claims processing costs without accounting for savings on the benefits side, but an accurate analysis of the cost of Medicare and TRICARE demands that you look at both. As an example, one reason processing TRICARE claims is more complex, thus more costly, is that physicians in the program are paid different amounts for the same procedures. That is because reimbursement rates are negotiated to get the most savings possible. You would save on processing if you make all the reimbursement rates the same, but you would lose whatever you are now saving by negotiating rates with providers. It is my strong belief that for many, if not most, of TRICARE's administrative costs, you will find a substantial savings on the benefit side.

Another issue contributing to TRICARE's higher processing cost is the wide range of coverages available under the three-tiered managed care benefit. While Medicare has one benefit package standardized nationwide, TRICARE beneficiaries choose from among the standard indemnity plan, a point-of-service network provider option, and an HMO-like option. Additionally, each prime contractor can offer its own unique menu of coverages in addition to the standard benefit.

There are also, of course, enrolled and unenrolled beneficiaries with a seemingly infinite number of possible combinations of cost and benefits. These choices and options and the constantly evolving benefits make TRICARE more attractive to the user, but much more complicated to administer. Processing these claims accurately in a timely manner is much more labor intensive than processing the standard claims for Medicare benefits.

This complexity also results in a tremendous number of inquiries from both beneficiaries and providers, primarily related to benefits, cost share, and claim payments. Inquiry rates are four times higher for TRICARE than for Medicare. In fact, we receive one inquiry for every 4.5 TRICARE claims. We are required to provide toll free numbers for these inquiries, which certainly seems to be a service that these beneficiaries deserve, but it adds significantly to the cost of processing claims. And while HCFA requires Medicare providers to use the contractor's automated response telephone system when checking on the status of claims less than 30 days old, there are no such restrictions on TRICARE providers.

Another difference between Medicare and TRICARE is size. The cost difference here derives from the principle of economy of scale, with which I know you are familiar. Each program has certain fixed costs, including software development and maintenance costs, fraud and abuse detection, and EMC marketing costs. Medicare's

fixed costs are spread over nearly 900 million claims a year, about 30 times the number of TRICARE claims. The huge volume of Medicare claims reduces unit cost. For example, $10 million in fixed costs to Medicare translates to just over one penny per claim compared to more than 39 cents per claim for TRICARE.

A major factor in claims costs is the use or lack of use of electronic media claims filing. The cost of handling paper claims is $2 or more higher than the cost of processing them electronically. Our Medicare division receives 85.5 percent of its medical and surgical claims electronically. We receive less than 20 percent of TRICARE medical and surgical claims electronically. If we could achieve the same 85.5 percent electronic rate, we would reduce our costs by 26 percent.

There are multiple reasons for this disparity in electronic filing. The biggest reason is that TRICARE rarely represents more than 5 percent of a provider's income, while Medicare typically represents 35 to 60 percent of his or her income.

Adding to this financial leverage Medicare has on a provider, HCFA has mandated that all paper claim submissions be held and not released until they are 27 days old. Compare that to TRICARE. Fifty percent of TRICARE providers submit ten or fewer claims per month. Ninety-eight percent of those claims are paid within 30 days, averaging 12 to 14 days. There is simply no financial reason for a provider to go through the additional hassle and expense of an electronic system for TRICARE.

Much of what I have said today has stressed the differences between these two programs. It is difficult to compare with an eye toward reducing the claims processing cost of two programs whose concepts are completely different. I would like to suggest to you that you might want to compare TRICARE with the Federal Employees Health Benefits Program, FEHBP, which, as you know, is quite highly regarded in terms of both benefits and administration and which is much more like TRICARE than is the Medicare program. Both are managed care programs, while Medicare is a fee-for-service program. My research shows that FEHBP and TRICARE have almost identical costs for claims processing.

Since we are comparing administrative costs for TRICARE with those of Medicare, however, let me quickly add that the General Accounting Office recently raised questions about the low administrative cost for Medicare. When cost is measured against future population growth in the Medicare age brackets, coupled with medical technology advancements and consideration of new mandates, William J. Scanlon, Director of Public Health Issues of the Health, Education, and Human Services Division of the GAO, testified before the Senate's Committee on Finance on May 4, 2000. Here is part of what he said, and I quote. "Contractor budgets for claims administration have been falling in proportion to the volume of claims they process. Relative to the size of private health insurers and their administrative budgets, HCFA runs Medicare on a shoestring."

Blue Cross and Blue Shield of South Carolina is eager to work with you on finding ways to reduce claims processing costs, and indeed, we are always working toward streamlining and improving

our processes. I appreciate your interest in my testimony and I will be happy to answer any questions.

Mr. SHAYS [presiding]. Thank you, Mr. Meyer.

[The prepared statement of William J. Meyer follows:]

PREPARED STATEMENT OF WILLIAM J. MEYER, SENIOR VICE PRESIDENT OF TRICARE, BLUE CROSS-BLUE SHIELD OF SOUTH CAROLINA

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There is a propensity to look at claims processing costs without accounting for savings on the benefit side, but an accurate analysis of the costs of Medicare and TRICARE demands that you look at both. As an example, one reason processing TRICARE claims is more complex-thus more costly-is that physicians in the program are paid different amounts for the same procedures. That is because reimbursement rates are negotiated to get the most saving possible. You could save on processing if you make all the reimbursement rates the same-but you would lose whatever you now save by negotiating rates with providers. It is my strong belief that for many, if not most, of TRICARE's administrative costs you will find a substantial saving on the benefit side.

Another issue contributing to TRICARE's higher processing costs is the wide range of coverages available under the three-tiered managed care benefit. While Medicare has one benefit package, standardized nationwide, TRICARE beneficiaries choose from among the standard indemnity plan, a point-of service network provider option, and an HMO-like option. Additionally, each prime contractor can offer its own unique menu of coverages in addition to the standard benefit. There are also, of course, enrolled and unenrolled beneficiaries, with a seemingly infinite number of possible combinations of costs and benefits. These choices and options, and the constantly evolving benefits, make TRICARE more attractive to the user, but much more complicated to administer. Processing these claims accurately in a timely manner is much more labor-intensive than processing the standard claims for Medicare benefits.

This complexity also results in a tremendous number of inquiries, from both beneficiaries and providers, primarily related to benefits, cost share, and claims payments. Inquiry rates are four times higher for TRICARE than for Medicare claims. In fact, we receive one inquiry for every 4.5 TRICARE claims. We are required to provide toll-free numbers for these inquiries, which certainly seems to be a service that these beneficiaries deserve, but it adds significantly to the cost of processing claims. And while HCFA requires Medicare providers to use the contractor's automated response telephone system when checking on the status of claims less than 30 days old, there are no such restrictions on TRICARE providers.

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Much of what I have said today has stressed the differences between these two programs. It is difficult to compare, with an eye toward reducing, the claims processing costs of two programs whose concepts are completely different. I would like to suggest that you also might want to compare TRICARE with the Federal Employees Health Benefit Program, which as you know is quite highly regarded in terms of both benefits and administration, and which is much more like TRICARE than is the Medicare program. Both are managed care programs, while Medicare is a fee-for-service program. My initial research shows that FEHBP and TRICARE have virtually the same costs for claims processing.

Since we are comparing administrative costs for TRICARE with those for Medicare, however, let me quickly add that the General Accounting Office recently raised questions about the low administrative costs for Medicare, when cost is measured against future population growth in the Medicare age brackets, coupled with medical technology advancements and consideration of new mandates. William J. Scanlon, Director of Health Financing and Public Health Issues of the Health, Education, and Human Services Division of the GAO, testified before the Senate's Committee on Finance on May 4, 2000. Here is part of what he said, and I quote: "* * * contractor budgets for claims administration have been falling in proportion to the volume of claims they process. Relative to the size of private health insurers and their administrative budgets, HCFA runs Medicare on a shoestring."

Blue Cross Blue Shield of South Carolina is eager to work with you on finding ways to reduce claims processing costs, and indeed, we are always working toward streamlining and improving our processes. I appreciate your interest in my testimony, and will be glad to answer any questions.

Mr. SHAYS. Other members are voting and they will be back to ask questions. My name is Chris Shays. I chair this committee along with Mr. Thornberry and I also chair the National Security Subcommittee that oversees all of DOD for all programs, including health care. While my Subcommittee on Government Reform has not really gotten into health care, we did get into health care issues when I chaired the Human Resource Subcommittee and it is an issue we are tremendously interested in.

Dr. Sears, I would like to have you just kind of describe to me your perception as you would be listening to veterans of all the reasons why they do not find TRICARE as satisfactory as you would like or as I would like.

Dr. SEARS. When you say veterans, sir, do you mean——

Mr. SHAYS. I do not mean veterans, I mean our military personnel.

Dr. SEARS. Yes. I think——

Mr. SHAYS. I might say also that my subcommittee also oversees veterans' affairs and we have focused time on veterans' affairs, so I let it slip there.

Dr. SEARS. I was afraid you were getting out of my area——

Mr. SHAYS. That is also my bias, that I eventually would like to combine both health care systems, too, so that is another issue.

Dr. SEARS [continuing]. Although many of our beneficiaries are veterans, obviously. Clearly, the major—as we track satisfaction, which, incidentally, has shown a trend of steady improvement since the beginning of TRICARE in each of the regions in studies and surveys done by outside consultants, clearly, the remaining challenge, the largest remaining challenge to us is the issue of access, and that revolves around the difficulties with telephone access, sometimes a problem of infrastructure in our military treatment facilities, particularly, and sometimes a problem with access to easy appointments and sometimes access to particularly acute care appointments.

We have made tremendous progress in those areas, but as Mr. Backhus pointed out, this is an area they are studying. It is an area where we have done a lot of work and there are significant improvements in place and many that are going in place over the next few months. But we must solve the telephone access problem, moving toward the utilization of a one TRICARE number nationally that downlinks, and looking at other issues.

The biggest problem we face——

Mr. SHAYS. You say one number. There is not one 800 number nationwide?

Dr. SEARS. No, there is not. There is an 800 number regionally——

Mr. SHAYS. See, I would have trouble understanding that. I mean, given that our military fly everywhere and go everywhere, why would that not have happened yesterday?

Dr. SEARS. We are talking about a number to access claims, and currently, the way the contracts are set, we have different contractors in different regions who manage that central phone, and in some reasons—so that you access it currently on a regional basis because you are enrolled in a particular region, so you get served by that region.

Mr. SHAYS. But they all have their own number. I use my Visa card and I enrolled in one place but I can go anywhere in the world and I can use it.

Dr. SEARS. Yes, sir, and that is where we are moving as rapidly as we can. The banking card issue, or the USAA, which is what our members talk to us about, is exactly where we are moving. That will allow us, when we put that in place, and that is in the works, to have one number that downlinks to all of our regions for both advice and appointments and other information, as needed.

Mr. SHAYS. If I said to my staff they are going to do something as rapidly as possible, I would like to know, what does that mean, and they have trained me to ask the same thing. What does as rapidly as possible mean?

Dr. SEARS. Well, we are in the process, first of all, of—we have an IPT, a team that is working on this issue. They have now worked with a number of the folks who provide these sorts of services and they are looking to the establishment of a 1–800 number capability sometime next fall.

Mr. SHAYS. Not this fall?

Dr. SEARS. No, not this fall, next fall.

Mr. SHAYS. That does not seem as rapidly as possible, then. That seems like on our own good time. You raised telephone access as a great aggravant—I did not, you did—and it would strike me that if that is the biggest problem, it is one of the easier parts of the problem to solve.

Dr. SEARS. There are several approaches to that, sir. One is through an improvement in our regional systems so that people can access that, and those initiatives, some of them are in place, some of them are going into place. But the larger problem of getting a downlink system that has the infrastructure and takes advantage of all the current technology is a longer process. We are striving to get that in place, obviously, as quickly as we can. We also have current contractual relationships in terms of some of those numbers that have to be modified. Contracts have to be modified to put that in place.

Mr. SHAYS. Well, it just strikes me, and I would think the other members of the committee, that doing it in a year and 3 months or so is not rapidly as possible.

What would be others besides telephone access? When I go out and I am listening to our men and women, they do not just tell me telephone access.

Dr. SEARS. No. The other major problem that we have had and are in the process of solving in very short order, this fall, is the issue of standardized appointments across our system. Right now, with the three military services doing appointing in different ways, using different appointment types, different templates, using different business rules for their appointing, we really have had a hodge-podge of different ways to get appointments.

We are putting in place now a standardized appointment system which reduces the number of appointment types from literally thousands in the past to a manageable number of eight or ten and building the templates that allow visibility of appointments to the folks who are doing the scheduling. If the appointing system is not properly structured, then even though you may have appointments available, they may not be obvious to the people who are making the appointments. That will be solved this fall.

We also have put out a software package that allows each of our military facilities to determine how they are utilizing their templates. It is called the template analysis tool. It allows them to make corrections in the way they are setting up their appointments so that they can correct their problems and make sure that the appointment availability is fully utilized. So those are very dramatic changes which will improve that access.

Now, as you know, under TRICARE, unlike CHAMPUS and our military health system before, we are trying to—we are guaranteeing our beneficiaries certain access availability. If you have an acute illness and need to be seen immediately, the guarantee is that you will be seen the same day. For routine appointments, we are guaranteeing a 7-day appointment standard. And for wellness visits and other consultations, up to 30 days.

For the most part, we are generally meeting those standards, and in the TRICARE system, if those standards cannot be met within the direct care system, within the military system, our re-

quirement is that they be referred into the network so that they can be seen in a timely way.

Mr. SHAYS. Let me just, before, Mr. Chairman, yielding back, just be clear on one thing. Our military personnel are sometimes called at a moment's notice. Is there the flexibility to meet a change in their schedule quickly, because they may all of a sudden find they are going to be out to sea for a few days?

Dr. SEARS. Absolutely. Active duty folks have the highest priority, and certainly deploying units would have the highest priority for attention to their medical needs as they prepare for deployment.

Mr. SHAYS. Thank you very much. Thank you, Mr. Chairman.

Mr. THORNBERRY [presiding]. Mr. Spratt.

Mr. SPRATT. I will waive any questions.

Mr. THORNBERRY. Let me ask, I guess, kind of a bottom-line question. We hear that the average cost to process a Medicare claim is $1.78. We hear that the average cost for the health insurance industry, I guess the private sector, is $3.50 to $4, ballpark maybe. And for TRICARE, it is nearly $8. You all have given a variety of factors that causes TRICARE to be higher. Some of those, I suppose, are factors we can fix and some of them are factors we cannot fix.

What I would like to get a sense of is, what do you think the goal ought to be? Are we doing as well as we can do? Is $8 or whatever it is as good as we can do, given the way that TRICARE is set up, or can we do better with electronic filing and other kinds of improvements? What should our goal be if things were running pretty well? Mr. Backhus, let me ask you to start.

Mr. BACKHUS. We asked ourselves and two claims processors that question, as well as the organizations that they process claims for, the TRICARE support contractors. We have analyzed the costs currently incurred in TRICARE. We have not looked at FEHBP at this point, but have a little bit of information on that.

It seems to me that the consensus around this is in the neighborhood of $3 or $4 per claim, which would be more like the industry average. There is $3 or so in costs per claim that are above and beyond the real cost of determining payment. Some of these costs like maintenance of information relative to who is using the system and to detect and deter fraud and abuse, are necessary expenditures.

But there are so many different edits in the program that probably are not necessary, and there is so much opportunity with technology such as potentially using the Internet and other more state-of-the-art systems, that I think we are talking, in my judgment, about $3 to $4 per claim.

Mr. THORNBERRY. Mr. Meyer, do you agree that we can save that much money if we get everything running right?

Mr. MEYER. I think if we did everything possible, this program would cost at least $5 a claim because of some of the basic inherent differences, and if you will just give me one moment, I will give you the best example I can, and that is our largest volume provider, we have five of the seven regions. We process 82 percent of the TRICARE claims.

The largest single provider we have across all five regions that does not submit claims electronically is the provider from the East Coast of North Carolina, a large group provider. They submit over 3,300 TRICARE claims per month, every month. They submit them all paper. We have been fighting to get these people to submit electronically.

Their answer to us is that they give TRICARE—they are a TRICARE Prime provider. They give TRICARE a 15 percent discount off the TRICARE rate for all their services. They are taking a 15 percent hit on the benefit dollars. Their electronic submitter is a company that charges them 35 cents a claim to submit claims electronically. Their paper TRICARE claims are getting paid in an average of 2 weeks.

They said there is exactly no reason for them to ever submit those claims electronically to us because they will be damned if they are going to give us—even though that 35 cents does not go to us, that is another 35 cents they would have to cut and they do not need the money in less than 2 weeks.

And that is the story over and over again. Once again, we could cut our costs 26 percent if we could get the same electronic rates as Medicare, and to say our electronic rate is 50 percent is a little bit misleading because most of that is pharmacy claims. Almost all of our pharmacy claims come electronically, but the hard claims, the professional claims and the surgical claims, only 17 to 20 percent of those come electronically.

Mr. THORNBERRY. I want to clarify that and get back to it in just a second, because I had that as a question, to resolve that difference.

But Dr. Sears, what do you think? What ought to be our goal here that we could achieve if we get everything running right?

Dr. SEARS. I think Mr. Meyer has hit it pretty closely. Obviously, we want to get the cost as low as possible, but I think the $2 to $3 range is achievable.

Mr. THORNBERRY. So we could save $2 to $3 per claim if we get everything going right?

Dr. SEARS. I think that is achievable with HIPAA, when HIPAA gets into place, when we complete all of our restructuring of edits and reviews and all of the simplification things that we are going through right now in our task forces that are looking at how to prevent rework of claims. I think further savings are achievable and should be striven for. The new technology, obviously, will also help significantly and it is in some ways hard to predict what cost savings can be achieved through the new technology.

Mr. THORNBERRY. Do you agree with Mr. Meyer's point that if you just look at, set pharmacy aside and the rest of the claims, only 17 to 20 percent are filed electronically now?

Dr. SEARS. That is correct.

Mr. THORNBERRY. And you, I think, said something about 50 percent, but that is only when you include all the pharmacy?

Dr. SEARS. That is right.

Mr. THORNBERRY. OK.

Dr. SEARS. That is correct.

Mr. THORNBERRY. Now, it is a little puzzling to me why it takes so long and seems to be so difficult to get electronic filing done, be-

cause, as you mentioned, Congress passed a law several years ago to require everybody to move in that direction, and you all seem to be saying we have no tools at our disposal to get these providers to file electronically. Are we making electronic filing too difficult for them? Do we have such a separate system for TRICARE with unique fields to be filled in and such special requirements for our computers that it is too difficult?

Dr. SEARS. Mr. Meyer is the expert in this, but if I am a physician practicing and I see a Medicare patient or a TRICARE patient, we use the same forms, the HCFA–1500 for individual providers and the UV–92 for hospital providers, the same form obviously for TRICARE and for Medicare. We have built things into the system now that mean that those claims could be submitted and processed—the same claim that could be submitted to the HCFA claims processor can be submitted to Mr. Meyer's organization and be processed.

Mr. THORNBERRY. OK. Mr. Meyer, if you are using the same form that you get anyway from Medicare providers, why can you not just use the same form and why can these doctors and providers not use the same form and e-mail it to somebody else other than——

Mr. MEYER. The form is the same, Mr. Chairman, but the data on the form is not necessarily the same, the data required on the form. There are some additional things that have to be put on that form for a TRICARE claim that does not have to be put on that form for a Medicare claim.

Mr. THORNBERRY. Are there some of those things we can get rid of?

Mr. MEYER. No, not really. You need to know branch of service, you need to know—there are TRICARE particulate you have to have. But let me say that that is not a large impediment. For the most part, that is a one-time cost, to modify a system to accept it for TRICARE.

The bigger impediment is, once again, more than 90 percent of the TRICARE claims we receive, excluding drug ones again, are coming from providers that submit less than ten claims per month. In other words, they are submitting 800 Medicare claims, three TRICARE claims. They say, we are not going to go through the expense of adjusting our automated system. It is going to cost us $400 to fix our automated system to accept TRICARE claims for three or four claims a month when you are paying them in less than 30 days anyway. There is no advantage for us to do that. We run into that over and over and over again.

Mr. THORNBERRY. I am sure it is just my ignorance. I am just not quite understanding why it should be so much more difficult, if you are already submitting so many Medicare claims, to submit a TRICARE claim on the same form.

Let me ask one last question and then see if my colleagues have questions. Mr. Backhus, you used the example of these electrocardiograms. Would you explain that to me? As I understand it, from one provider alone, 14,000 claims for electrocardiograms were all sent over here for manual review. Now, I presume that means somebody looking at each piece of paper and approving each of those claims manually, when none of them are ever denied. Can you explain that to me?

Mr. BACKHUS. I will try. The history of this dates back to program requirements that preceded TRICARE. At a time when CHAMPUS was in place and the Department of Defense was, in fact, a direct payer of claims, there was a feeling that there was a need to screen claims for many different kinds of services, in other words require that claims for many different services be edited and reviewed for medical necessity. In this particular case, the requirement was for all electrocardiograms claims to be manually reviewed for that purpose.

Now that TRICARE is here and the contractors have some fiscal responsibility for the costs, the responsibilities for determining medical necessity and appropriateness rests in many cases with them. However, technologies have changed and utilization has changed, and thus, in some cases, the need to review services in particular have changed.

Electrocardiogram claims fall into that category, but the requirement did not change. It is outdated, probably needs to be—in fact, recently, a policy has been put into place, as I understand it, to permit the contractors now to remove that particular edit from the claims processing system. It is not in place at this point, but it should be within a few months.

The other thing I would like to clarify is that the 14,000 claims are from one particular TRICARE contract, one particular region.

Mr. THORNBERRY. We do not want to make too much out of each individual instance, but I think it is helpful for us to get a feel for some of the problems that we are trying to sort through and why these costs are so much, because obviously if you have got to go through 14,000 pieces of paper, each one and every one gets approved, then that is an unnecessary expense in a variety of ways and it is one example.

Mr. SPRATT. Would the gentleman yield?

Mr. THORNBERRY. I would be happy to yield to the gentleman.

Mr. SPRATT. With respect to your cost, I am not quite clear as to your testimony. You testified, Mr. Meyer, that in addition to just the direct cost of processing a claim, you are also handling the network, responding to provider inquiries, responding to patient inquiries, and trying to make this managed care network an efficient provider as opposed to just some fee-for-service situation where you pay whatever the charge says to pay.

Are you saying that when you give us your per claim estimate of what it costs to settle one claim, pay one claim, you are dividing the number of claims into the total compensation you receive from managing this whole program?

Mr. MEYER. That is correct, Congressman. Typically, claims processing costs in this program includes all the things you just mentioned, includes providing the telephone service, the toll-free lines, the responding to written inquiries, the management of the provider file and pricing files. It is all rolled together. The cost to actually process the claim with none of that itself is $2 and some odd cents.

Mr. SPRATT. So it is pretty close to Medicare, the actual claims management aspect.

Mr. MEYER. Right. But in fairness, Medicare includes the cost of processing the inquiries and they are $1.78. So the $1.78 for Medi-

care and the $7.50 for TRICARE is as close as you can get to apples to apples for the different requirements.

Mr. SPRATT. But does the $7.50 include all of these other managerial responsibilities?

Mr. MEYER. Yes, it does, and many of those, Medicare does not have. Medicare does not have to manage the one million provider file that I have to manage. It is very, very small compared to that.

Mr. SPRATT. To what extent do you have to nourish the network? Do you have to deal with providers and try to coax and persuade them to stay in the network? I know in South Carolina, which is under your purview, we have had a problem with the TRICARE network, first of all building it up and filling out different aspects of it, and then keeping some of those who signed up originally in the system.

Mr. MEYER. Yes, we do that, Congressman. We have a very—it is probably 60 cents a claim that we spend on just maintaining those provider networks. It is classic, for example, for one doctor to belong to one group and be in the network in that group and belong to another group at the same time and not be in the network in that group, which is legal but not ethical. He can manage his fees that way. In other words, as a part of the network in this group, he is going to get paid $50 for a service, but in this other group, he can get paid $75 for the same service, so he will move over to that group to get that service done. We have to manage that. There are over one million individual providers on our provider file that we have to manage the pricing on those things and the complexity is just enormous, and that is 60 cents a claim that Medicare does not experience.

Mr. SPRATT. I thank the gentleman for yielding.

Mr. THORNBERRY. I thank the gentleman.

Mr. Buyer.

Mr. BUYER. Thank you, Mr. Chairman. Back to the hearing that we had this past spring, of all the hearings that I have ever attended or chaired in Congress, as I look back at that one, it was 5 hours. It was a marathon hearing that we had, but it was also one of the most productive I think that I have ever participated in because we talked about TRICARE. No one could duck anything. They were all in the room. I was going through the white paper that one of the companies had submitted and I wanted to touch on a couple of things.

If we were to, back to the chairman's initial questions of you, to get at it quickly, when you talk about—I would appreciate your testimony about what are the front costs and then discuss the inquiry rates and why is there such a differential in the inquiry rates between Medicare and TRICARE, and those are two huge cost drivers.

Mr. MEYER. Absolutely. Let me take the inquiry rates first. We have, once again, we get more than five million telephone inquiries per year for our claim volume, one phone call for every four-and-a-half claims. One of the reasons why that is so different compared to Medicare, and it is an important point to make, is that our research has shown that 50 percent of our phone calls are people, mostly providers, calling to find out the status of the claim. Sixty

percent of that 50 percent are phone calls on claims less than 30 days old.

In Medicare, those phone calls must go through the automated voice response unit. In other words, a doctor cannot opt past the automated response unit to a human attendant. In TRICARE, there is no such prohibition. Virtually 100 percent of them go right past the automated response unit and come to an individual to answer. This usually inflates the volume of phone calls. I would go on a limb to say 30 percent of our phone calls could be eliminated if we required, as Medicare does, those providers to use the automated response unit for claims that are less than 30 days old.

Once again, more than half the phone calls we get on claim status are claims for 8 days old, 10 days old, 12 days old. It is routine. We have the same providers call every Monday and they call on the list of every claim they have submitted. Even if the claim was submitted last Thursday, they are calling for the status on a Monday. They read off 50 claims and they want the same status.

Mr. BUYER. What had been submitted to me was that—and I wish you would concur or not concur—that with regard to Medicare, you receive one inquiry per 18 Medicare claims.

Mr. MEYER. That is correct.

Mr. BUYER. TRICARE, it is one inquiry for 4.5 claims.

Mr. MEYER. That is correct. That is the ratio.

Mr. BUYER. That is almost five times the amount.

Mr. MEYER. It is exactly four-to-one, right.

Mr. BUYER. That is stunning, especially given the volume of Medicare claims you process versus TRICARE claims. So this issue of moving toward greater simplification——

Mr. MEYER. It is a huge benefit.

Mr. BUYER [continuing]. It is a huge benefit. Will you share with the committee a breakout of what you meant by front costs? If the front end costs were—front end costs are handled different ways.

Mr. MEYER. Right.

Mr. BUYER. Break that out. Define that for me.

Mr. MEYER. That is the mailroom, the place that receives the 25 million claims that we receive. That is the cost for coding all those claims and data rendering all those claims into the system. That is the cost of passing the paper around, collecting the paper, and then, in fact, sending the paper off to storage places for that paper to be stored, because, frankly, the Federal records centers are all full so we have to absorb the cost of retaining 25 million claims and associated correspondence per year.

Mr. BUYER. So you threw in mailroom, document preparation, imaging, distribution, data entry, paper storage, according to this white paper by your company, it could add up to $1.35 to $1.50 per claim.

Mr. MEYER. Right, Congressman. Since we did that paper, we looked at it closer and it is actually closer to $2 per claim.

Mr. BUYER. That is almost equivalent to the cost of Medicare alone, and that is just the front cost.

Mr. MEYER. That is correct.

Mr. BUYER. That is pretty stunning when you think about that.

Mr. SPRATT. Would the gentleman yield?

Mr. BUYER. Yes.

Mr. SPRATT. Is some of this due to the fact that this is a new program, you are just getting accustomed to it, getting your providers in the groove, so to speak, and they therefore have more inquiries, they need more guidance?

Mr. MEYER. The inquiries in this program—well, yes and no. For example, we get more inquiries on the newer contracts than we get on the more mature contracts. For example, we process claims for Regions 9, 10, and 12, which is the States of California and Hawaii and Alaska. The ratio of calls to claims there is lower than the ratio of calls to claims, for example, in the Mid-Atlantic region, which is one of the last regions to come up, where people are still getting used to the complexities of the TRICARE program and still do not understand what the benefit is and what the cost share is all the complexities associated with the program.

Mr. SPRATT. If you had electronic filing, do you avoid most of this front-end cost?

Mr. MEYER. If you have electronic filing, you avoid all of the front-end cost.

Mr. SPRATT. Gee whiz. Do we give providers the software, or do they have to buy proprietary software?

Mr. MEYER. We have a free product that we offer every single provider. We say, this is absolutely free to you, this software. As a rule, once again, they are already using another software package and they are using it primarily for Medicare or they are a large commercial carrier and they say they do not want to run two packages, even though it is free. They have a large vendor that does this for them and they do not want to run the second package, and thanks but no thanks.

If there was a way to do it, we would eliminate that paper tomorrow. It would drop right down to our bottom line. There is no reason not to do it.

Mr. SPRATT. If the gentleman would yield still, does the software we provide free integrate easily with most operating systems?

Mr. MEYER. Yes, it does. It is on a floppy disk. You pop it into your computer and away you go. We will have the capability within 1 to 2 months for anybody, any provider in the country to submit TRICARE claims across the web. All you need at that point is government permission to get past whatever security issues that they have. We believe we have that conquered and then 100 percent of all providers in the country can file electronically across the web free.

But my prediction is they are still not going to do it, because once again there, they have thee large systems in place that they are submitting from Medicare, which is 50 percent of their income, and they are going to say, that is what I am using and that is all I am going to use. We may pick up some around the edges in the three or four claim per month providers that say, well, we can get them done this way.

Mr. SPRATT. Do most of these providers also have a separate software package for Medicaid in their particular State?

Mr. MEYER. I could not answer that question for Medicaid. I can look it up for you. For Medicare, I know, but not for Medicaid. I would not know.

Mr. SPRATT. Blue Cross-Blue Shield, do you provide your PPOs and others who are approved providers, do you provide them with software for submission of electronic claims?

Mr. MEYER. Yes, we do.

Mr. SPRATT. And is the acceptability rate there high?

Mr. MEYER. Yes, it is, and once again the reason is the financial leverage on the doctors we have in the State of South Carolina. For the most part, we represent anywhere from 33 percent to 80 percent of their income.

Mr. SPRATT. Again, it is market share.

Mr. MEYER. Right.

Mr. BUYER. We were very cautious when we did the defense bill not to place the mandate to electronic filing. We have Dr. Sears here and Mr. Backhus. Let us explore that for just a moment.

Mr. Backhus, on page 7 of your written testimony, you indicate that one of the challenges in reducing the cost of TRICARE claims processing is increasing the number of providers who are submitting claims electronically. You indicate that this is not likely to happen without either incentives or mandates. I agree with your assessment that mandates might actually drive providers away from TRICARE.

What kind of incentives can be used to encourage providers to make more use of electronic means of filing claims, to make sure that that does not happen? I mean, how do we work cooperatively here, DOD with contractors and providers, to make sure that does not happen rather than Congress coming in and saying, you cannot get it right. We are just going to mandate and we are going to micromanage.

Mr. BACKHUS. First of all, if these HIPAA requirements do come to pass and data submissions are similar for every program, then that would go a long way toward providing incentives for people to do this that would not require their own separate systems and software packages.

Secondly, you know, Medicare, as Mr. Meyer pointed out, has tried to provide incentives for electronic claims processing by permitting, or actually requiring, that the paper claims not be paid in less than 26 days, whereas electronic claims, of course, can be processed and paid much quicker. The same possibility exists here to do this. He says his company processes the paper claims in 2 weeks.

Mr. MEYER. On average.

Mr. BACKHUS. On average, and the standard is 30 days. It may not be popular, but it is possible that if paper claims were paid something closer to 30 days, it may offer these folks an incentive to submit electronic claims because they will get paid quicker. Now, as he says, if they are going to get paid in 2 weeks with the paper claim, what reason do they have to change?

There is another opportunity here that I think exists that is more technical in nature and Mr. Meyer can probably explain it better than I can, but, for example, there are opportunities for TRICARE to try to adopt the Medicare provider identification numbers. What this means simply is that when a TRICARE provider wants to file a claim, their unique identification number does not fit into the current TRICARE electronic formatting and contractors

have to convert their systems to try to adapt if they want to file under TRICARE.

There is a possibility to go ahead and allow these folks just to use their Medicare numbers, for the TRICARE system to recognize that, convert it over to whatever the particular network is that this TRICARE provider is associated with, and process the claim that way.

Mr. BUYER. Mr. Chairman, may I be permitted a little latitude? Dr. Sears, would you please comment on what we have just heard from these two other gentlemen's testimony——

Dr. SEARS. Sure.

Mr. BUYER [continuing]. Because you have some kind of responsibility here.

Dr. SEARS. Yes, sir. What you are hearing described is a delicate balance that we have, in part, in attracting providers and keeping providers in the network, and the service that is provided to the provider is very important to the provider both in terms of the ability to access about inquiries and the ability to get paid in a timely way. And so often, we hear from provider groups that they are willing to stay, they do not like the reimbursement, but they are willing to stay because they are getting paid in a timely way and there is a customer service feature that has been helpful to them. So I think you can see the tension there between mandating, which, as has been pointed out, could drive people out of the system and the other approach.

Again, Mr. Meyer is the expert here, but the government has given approval to the contractors to use the UPIN, the Universal Provider Identification Number, and we used to require that, I believe, the tax ID number and a sub-identifier, but there is now an ability to crosswalk between the UPIN number and the tax ID number, so that should not be an issue.

Mr. SPRATT. Will the gentleman yield?

Mr. BUYER. Yes.

Mr. SPRATT. Mr. Meyer, Mr. Backhus mentioned HIPAA and standardization, and I understand that your particular company has a problem with standardization. According to your experience, it turned out to be much more complex than it would seem and it is also going to be very costly. Would you care to comment on that?

Mr. MEYER. Well, I think you just said it, Congressman Spratt, that our experience in our company is we do not—it is not that we disagree with HIPAA. We just feel that by the time the smoke clears on HIPAA, the cost for administration, for the implementation of HIPAA will probably be four times higher than what is currently being said. We think there is a huge cost to doing it and it is going to drag out over a protracted period of time. I have very little confidence that it is going to be in 2 years like they say it is going to be. The way the committees on that are progressing, they are just not progressing at all.

Mr. BUYER. I want to switch gears for a second, because Dr. Sears, one item in your written testimony concerns me a great deal. You state the Department is evaluating contractor proposals to eliminate the TRICARE Encounter Data System as a replacement for the Health Care Service Record. The committee staff has worked closely with you and in the 2001 Defense Authorization

Act, you specifically requested and we put in the bill $3.1 million to finish the work on TEDS. So what is up here?

Dr. SEARS. We have no—we are studying, as the testimony says, but our intention is moving to replace the HCSR, the Health Care Service Record, with the TRICARE Encounter Data, again——

Mr. BUYER. You intend to finish the work on TEDS?

Dr. SEARS. We intend to implement that. We are always looking at ways to do business in a better way, and this has been a very strong demand from our contractors, to look at another way of doing this. So we are looking at that. We are working with them. But that has not impaired in any way our implementation or our switch from the HCSR to the TED.

Mr. BUYER. OK. You see, we want to be helpful here and be responsive and that is the challenge we have made not only to you but under the contractors, and so if you have asked us to fund a particular system while you are also looking, we want to make sure we are casting good judgment.

Dr. SEARS. You are and it is appreciated and we are proceeding, and we appreciate the language in the bill this year that supports that.

Mr. BUYER. Thank you, Mr. Chairman. I will have a second round of questions. I yield back to the chair.

Mr. THORNBERRY. Mr. Shays.

Mr. SHAYS. Thank you. I am still wrestling with something that is kind of silly, but I am still wrestling with it. If you are telling me the primary negative that your recipients have to health care is access and just finding a real live person or getting information, and you are telling me that you do not have a uniform number for people to call in this day and age, and then you are telling me they are going to do it as rapidly as possible and rapidly as possible means next September, not this September, I am just wrestling with the question mark as to why, if this is a serious problem, at least in terms of product satisfaction, it could not be done in a month or two.

Why can they not call an 800 number? Why can the 800 number not know exactly where it is coming from and refer to the, I guess you have 11 regions, is that correct?

Dr. SEARS. Twelve regions.

Mr. SHAYS. I mean, the average stay that a military person has in one area has got to be relatively small. So of all the organizations that should want to do this, I would think you would want to do it before almost any other organization. Mr. Meyer or Mr. Backhus, tell me why it would be a problem to do this sooner than 15 months from now. Why could it not be done sooner?

Mr. MEYER. Congressman, I think there are actually two issues on the telephone that Dr. Sears is talking about. One is the phone system where people call to get appointments.

Mr. SHAYS. Right.

Mr. MEYER. And the other is the phone system they call if they have claims questions. I think one phone number could handle it for the claims questions and another phone number—two phone numbers, one phone number for claims issues and another phone number for appointments and I think that could be done.

Mr. SHAYS. In the private sector fairly quickly, correct?

Mr. MEYER. I am sorry?

Mr. SHAYS. In the private sector, fairly quickly?

Mr. MEYER. Yes.

Mr. SHAYS. Mr. Backhus, you made some specific recommendations that would be helpful and one of them was dealing with the perennial and daily problem of fraud. What I was struck with was your pointing out there are 40 million claims processed from January 1999 through April of 2000. Only 17 fraud referral cases from the contractors have been accepted by DOD for investigation. That boggles my mind. I mean, that seems so tiny, and I would like you to just talk about it a bit.

Mr. BACKHUS. OK. A year ago, or about a year ago, we looked at this issue extensively. While recognizing TRICARE is a different program than Medicare, and the two are hard to compare, we were struck by how relatively little activity there was at the contractor level in terms of the referrals that they were making to other parts of the Department of Defense involving potential health care fraud. We asked why and how this could be, and what would one expect out of a program this size. We learned that while there are requirements in the contracts for the contractors to have programs in place to do certain kinds of analyses of claims, to look for patterns and trends and things like that, they were very poorly staffed.

Mr. SHAYS. And is the reason because they have no financial incentive?

Mr. BACKHUS. No.

Mr. SHAYS. In other words, it is not their money?

Mr. BACKHUS. No, they do have incentives. This is the odd thing about it. They do have, in many cases, the incentive to do this because they are at risk for the health care costs that are incurred. It just did not seem to be something that they had yet pursued with the vigor that ultimately they ought to.

Mr. SHAYS. Well, how much are they at risk and how much is the government at risk? What is their risk?

Mr. BACKHUS. That is a complicated thing. I am not so sure I can give an easy answer to that question.

Mr. SHAYS. Give me your best effort.

Mr. BACKHUS. Essentially, the contracts are fixed price. The simple explanation is that for the population that the contractors are serving, they bid a fixed price for those services. If the costs exceed what they have bid on and were awarded in the contract and those costs are not attributable to unforseen circumstances, such as population shifts and things like that or inflation, unanticipated inflation, then they are at risk for a portion of those excess costs shared with the government.

I am having trouble. I would have to provide for the record what that split is, but I think Dr. Sears probably has——

Mr. SHAYS. Mr. Meyer, can you help me out here?

Mr. MEYER. It is 80/20, Congressman Shays.

Mr. SHAYS. So who has the 80?

Mr. MEYER. The government does.

Mr. SHAYS. And the contractor has 20? And we have a measly 17 cases out of 40 million?

Mr. MEYER. Congressman, once again, I am a little bit troubled by the numbers in that I know I have right now several thousand

claims suspended for fraud investigation. So, you know, sometimes a case might involve 8,000 or 9,000 claims. I think you have got a little bit of apples and oranges here again. We talked about 40 million claims and 17 cases. Those 17 cases can represent a whole lot more than one claim per case.

Mr. SHAYS. I understand that, but if only 17 organizations or people were prosecuted—is that what I understand to be right, Mr. Backhus?

Mr. BACKHUS. No, these are active cases.

Mr. SHAYS. That would not strike fear in the hearts of someone who is seeking to get payment, if 17 out of—but the cases are 40 million, so your point is that there are not 40 million vendors, obviously. But in our work with Medicare and when we recommended that we have health care fraud be both a Federal and State offense, that it would be both Federal as well as State so people could not go from one area to the other, I mean, we are capturing billions of dollars as the result of those changes.

I guess what I am interested in is, what would you recommend, Mr. Backhus, to beef up this effort? I mean, I am going to make an assumption that I do not have to be a rocket scientist to, that between fraud and abuse, we have got billions of dollars at play.

Dr. SEARS. If I could answer that, sir——

Mr. SHAYS. Yes.

Dr. SEARS. First of all, the 10 to 20 percent is really felt to be an inaccurate projection of what the fraud and abuse is. The National Health Care Anti-Fraud Association feels it is between 3 and 5. Now, I am not belittling the problem——

Mr. SHAYS. But between 3 and 5——

Dr. SEARS [continuing]. I am just saying the magnitude of it is not as great as it may have been portrayed. We have probably the leading industry piece in terms of pre-pay edits and edits in the system that detect abusive claims, many of which are potentially fraudulent claims. So those are identified in the system before the claim is paid, and with the prepaid edits, that amounts to about seven million in claims saving a year, and in the software that detects inappropriate or potentially abusive or fraudulent claims, we save about $87 million a year in that area.

Mr. SHAYS. What is the total expenditure that we make, $8 billion? Out of how much? I am trying to understand the overall billing.

Dr. SEARS. The total purchased care dollars that we expend is about $2.9 billion for purchased care in our system. We have, in the last year, year and a half, instituted what is called the Operation TRICARE Fraud Watch, which is a very aggressive approach to address many of the issues that Mr. Backhus raises. We have required, are requiring—it is not totally in place yet but it is going into place—artificial intelligence software that we have mandated that each of our contractors use to further identify potential cases of fraud that then can be identified.

We make a major contribution through our national database, our TRICARE purchased care database, in support of HCFA, the FBI, the Defense criminal investigators——

Mr. SHAYS. I am just going to interrupt you and let others ask questions.

Dr. SEARS [continuing]. How to do that.

Mr. SHAYS. The bottom line is, there is 17 out of 40 million.

Dr. SEARS. Yes.

Mr. SHAYS. That is the bottom line, and the bottom line, that would suggest that there is not the aggressive effort.

Dr. SEARS. Yes. Now, that is not all the referrals that we get. Those are the referrals that we have gotten that we feel where there has been potential harm done to the patient or where there is significant recovery. There would be a number of other submittals to us that get returned to be investigated as abusive claims rather than fraudulent claims.

But frankly, that is—I do not want to be misunderstood here. We think that is a low number also, and it has become a special interest item with our quarterly meetings with our contractors where we review their turning over to us for potential fraud cases, and we expect that to increase. In fact, we are seeing increases, not as dramatic as we had hoped, but we are seeing increase this year in referrals and anticipate with the utilization of the additional software piece and all of the other educational efforts—we have required the contractors to put on the explanation of benefits forms a fraud hotline number. The EOB is one of the great detectors of fraud and we think that is an effective way. We have established a web page that also identifies sanctioned providers and gives people the direction and providers the direction in terms of how to report fraud.

Mr. SHAYS. Let me thank——

Mr. BUYER. Would the gentleman yield to me for a moment?

Mr. SHAYS. Sure.

Mr. BUYER. I have listened to this and I am not completely satisfied that, despite what you have testified to, Dr. Sears, is completely responsive to Mr. Shays. That is my personal observation.

What we have here is Mr. Backhus, with regard to his interest in the Department of Defense efforts to implement an effective system for identifying waste, fraud, and abuse, comes out and says, we have identified potential losses of up to $580 million. Mr. Shays and the Budget Committee's reaction to that is appropriate. I think that is incredible. Then when you add to that and say that 17 cases of potential fraud were accepted from the managed care support contractors by the Department of Defense for investigation is stunning.

So let me pause for a moment here, if I may, Mr. Shays, and let us turn to Mr. Backhus here and let us try to put the ketchup back in the bottle. Mr. Backhus.

Mr. BACKHUS. I am not sure what you are asking me.

Mr. BUYER. What I am asking here is, of the $580 million, what all is that and give us your judgments here or your observations about why the Department is giving the answers that they are giving here.

Mr. BACKHUS. I suppose the first thing I need to say is that I doubt—I would say it would be impossible to ever, ever pinpoint or be precise as to what this upper limit is. The estimates that comprise or make up $580 million come from a number of different sources, from people in the business who are talking 10 to 20 percent. It is fraud, waste, and abuse, not just fraud, necessarily. It

is important to distinguish and to make clear that it is not always criminal kinds of fraud but there are over-billings and things like that, possibly unnecessary care and things like that which are included in this. So that accounts for, I think, the difference, potentially, between 3 percent and something in the neighborhood of 10 to 20 percent. So we are talking about lots of things here.

The activity—in response to the report that we wrote last year on this, the Department has been responsive in several ways. Giving it attention was the first order of business here, and there was at the time nothing in the way of strategic planning or emphasis, in terms of management attention, that we could see that existed. Since that time, there is now in place an emphasis that has been placed on this from the top. They do have prepayment edits. They identify over-billings in some cases and things like that.

But in preparing for this hearing today what we tried to do was to find out exactly what has changed in the way of additional kinds of analysis, mostly in an automated way, that are being made of the claims that are submitted, either provider profiling, trending, patterns, billing practices, at the contractor level. This is a level above where Mr. Meyer works—the people that he contracts with to process claims.

There is software available around to do this that matches claims together to determine potential issues involving fraud, mostly. The software is available. The Department of Defense has identified that software and wants their folks to use it, but as I understand it, this stuff is not going to be loaded by the contractors until the end of this fiscal year, sometime in the September-October time frame, and until that happens, I suspect that we are going to see much the same kind of——

Mr. BUYER. Of the $580 million. So you have got the fraud side of it, you have got abuses of the systems, and then you have waste, and that is sort of what we are looking at here, is how we bring efficiencies to the systems.

Let me shift gears for just a moment. This is a unique opportunity, so I have to ask this question. We conduct our hearings on the Armed Services Committee. We work with you. We sort of move toward solutions. Now you have an opportunity to examine what we have placed in the Defense Authorization Act. We chose not to give you an actual mandate, come in and mandate, and we talked about some of those concerns. But what we gave you was a goal, to move to 50 percent of the non-pharmaceutical claims.

Do you know what that sort of is? We are telegraphing exactly where we are coming from. We want to see if you can achieve the goal, because if you do not achieve the goal, you know exactly what Congress is going to do and it will be mandates. So my question to you is, how realistic will you be to achieve the goal so we do not micromanage? Dr. Sears.

Dr. SEARS. Are you asking if the goal is realistic?

Mr. BUYER. I want to know if you can achieve the goal without Congress having to mandate electronic filing. Can you do it on your own?

Dr. SEARS. We certainly feel that that is achievable. As Mr. Meyer has pointed out, it is difficult, but we will certainly—I think the 50 percent level is going to be difficult and I would just be re-

peating what has been stated before in testimony, but we certainly have a full court press in terms of our attempts to convert, particularly as you stated in the legislation, that we would, as you stated, that we would identify the high-volume providers. We have directed the Secretary to identify the high-volume providers in an attempt to get that level up to 50 percent, and we will pursue that vigorously. I have——

Mr. BUYER. Let us be specific. Full court to achieve, full court press to achieve is your quote. What is the date to implement a web-based system of open architecture? When is that going to happen? Give me an idea. It was supposed to have occurred by May. Is it going to happen? I mean, if you can say full press, that should have happened by now. When is this going to happen?

Dr. SEARS. As you know, our contracts are established and requirements are put in those contracts that are met. Changes in those change. Some of the web-based systems are currently online. They are in place. They are being utilized. In terms of looking up, the status of claims and other enhancements will go on those.

As Mr. Meyer mentioned, they are moving toward the utilization of web-based capability to submit claims. Those things are underway. We are supporting with our contractors discussions that may lead to other approaches to this. So there is activity, there are things in place, and this is progressing.

But it will take new contracts to bring a total system across—a total approach across the system, which is one of the things that is difficult that we cannot move as rapidly as we would like to and as we see the right way to move. But in the meantime, things are going into place and in the new contracts, with the requirement that our contractors use best business practices, obviously, a good share of those things will be a part of those new contracts.

Mr. BUYER. Mr. Chairman, may I have one more? I think this has been very helpful and productive and I want to thank the Budget Committee. We have talked about different pillars here relative to why it costs so much, whether it is front costs, inquiry costs, how we can reduce actually the human element in touching this administration.

Mr. Meyer, I think your testimony was very helpful. The theme I received from your written testimony is about the complexity of the claims processing. I think the other pillar is the complexity of these claims versus Medicare. So in our system, you have got to look at it and you say, well, how do we move to data warehousing? Right now, you go, OK, a claim. Are they active, pending, TRICARE, standard, prime, senior, extra, how were the rates negotiated, portability, who pays what, competition between regions, not my responsibility.

Mr. MEYER. Right.

Mr. BUYER. Wow. So how do we move toward streamlining, all right, and I would be interested in your views here. Actually, for all of you gentlemen, how do we move toward streamlining, reduce the complexity without actually reducing the benefits at the same time?

Mr. MEYER. I think the Department has begun to do that. I think the work simplification efforts in the past year are beginning to get away from the fact that 14,000 electrocardiograms had deferred the

year before for somebody in my shop to look at the paper and say it is appropriate and pass on. That is times 400 other deferrals just like that. That has begun. The Department has told us, do away with that. That does not make any sense. That is a carryover from the CHAMPUS days. So that is being done away with and that will simplify the program.

I think Mr. Backhus discussed earlier today one of the big hangups on electronic claims has been our being unable to accept the Medicare provider numbers. The Department has now said, you can now accept the Medicare provider numbers. We have to build a crosswalk system behind it, but that is an impediment that is being blown away. So one by one, these things are coming away.

I guess my caution is that nobody should believe that at the end of the day, when all of it goes away, we are going to be at $1.78, because we are not.

Mr. BUYER. Mr. Backhus or Dr. Sears? Dr. Sears, then Mr. Backhus.

Dr. SEARS. Obviously, the example I gave in my opening statement about ultrasounds is another one of the examples. As we determine things that have no yield, that do not reduce health care costs or improve quality, those things are being removed. I could provide for the record, if you wish, a very extensive list of specific initiatives that are being undertaken to remove the complexity, unnecessary edits, and other approaches that we are using to simplify claims.

Mr. BUYER. Mr. Chairman, Dr. Sears has offered it to the Budget Committee and I think it would be helpful, if you would so order.

Mr. THORNBERRY. We will look forward to receiving that list. Thank you.

Dr. SEARS. Very fine.

[The information of H. James T. Sears, M.D., follows:]

[RESPONSE FROM DR. SEARS PENDING]

Mr. BUYER. I did not mean to interrupt. Were you concluding you would provide it to us written?

Dr. SEARS. Along all these lines, there are tremendous efforts underway to move this along. There are certain very significant impediments that we face that make it difficult to simplify or do some of the things that we would like to do in the system, and the fact that we have open enrollment, or that we do not have all of our members enrolled, is a significant impediment to us, and there are other issues like that that make it difficult to negotiate. But where we can find solutions, where we can remove these impediments, that is being done right now.

Mr. BUYER. Mr. Backhus.

Mr. BACKHUS. Well, we have obviously taken the position that we have positive reactions to all the initiatives underway. We have been monitoring them but have not evaluated them up to this point in detail. But they are clearly the right things to do.

The only concern I really have at this point is, I guess I am hearing the same thing from you, and that is how long is it going to take? I have seen a number of initiatives come and go in the past, so I will be looking here for sustained commitment to make these kinds of changes. I think, in many respects, these folks know what

to do, but this bureaucracy sometimes just kind of makes it hard to do.

Mr. BUYER. Thank you, gentlemen.

I want to thank the Budget Committee for permitting me to sit with you here as we explore these issues. I think they are extremely important, and I also want to compliment you as you work in a bipartisan fashion. This is a really important issue to the troops out there because what happens is exactly what both of you had mentioned earlier, and in particular Mr. Moran.

I do not necessarily agree with Dr. Sears' testimony earlier about that, well, all these payments are being made timely. They are not being made timely. Some of the contractors are not getting paid on time and then they take those bills and they drop them right on the soldiers and the soldiers do not have the money and then they end up with all of the bad credit ratings and, guess what, guys, they call us. So it is a system that begins a vicious circle. It is circuitous.

So I think all this is very important, and the more light we shine on this, the more we can move to productive solutions. I want to compliment the Budget Committee. We from the House Armed Services Committee would enjoin and work cooperatively with you in the efforts toward moving toward a solution. Thank you, gentlemen, for the bipartisan effort.

Mr. THORNBERRY. We appreciate the gentleman participating. He has added a lot in trying to get to the heart of the matter and we thank him for his time.

Mr. Moran.

Mr. MORAN. I do not have anything further to add because I think the questions that needed to be asked have been asked. I just had one thing that I cannot figure out right away.

You said that it costs on average $2 extra to do the processing the way that you feel you have to do and that the principal reason is because these providers, they just do not have enough claims to make automation make sense, to automate it completely, because it costs on average 35 cents per claim, or it would cost the providers 35 cents per claim to automate their system, as I understand it, on average, and why should they incur that expense.

But why could you not incentivize it by saying, we will pay you, not only give you free software but we will give you 50 cents a claim. So if it costs you on average 35 cents a claim, we will give you an extra half-buck per claim. So now you have no economic reason not to automate it and we are better off, the Defense Department, because we are saving $2 a claim. Can we not give them some of the money that we would save, or am I missing something?

Mr. MEYER. You, in fact, can do that. That would be up to—I am a subcontractor. That would be up to the prime contractor, because that money would have to come out of their pocket, to make that decision.

One of the issues in making that decision is right now there are many providers who are paying for the service. So if I am paying for the service and the guy next door to me all of a sudden starts getting paid for the same thing, I just created chaos inside that network. I am just speaking frankly, what would happen. Everybody that is currently paying for the service the next day is going

to say, I am not paying for it anymore. It might be a good thing to happen, but that is what would happen and there would be an interim period of time where there would be chaos going on because some guys are paying for something somebody else is being paid to do.

Mr. MORAN. But our interest is in reducing that $2 extra that is attributable to the non-automation.

Mr. MEYER. Clearly.

Dr. SEARS. We pay claims at the maximum allowable rate, so theoretically, under the law, we could not add money to that rate.

Mr. MORAN. You cannot by law?

Dr. SEARS. We pay at the maximum allowable rate for our TRICARE.

Mr. MORAN. Could the authorizing subcommittee do something there that would enable them to incentivize it so that it does not cost 35 cents, on average, a claim?

Mr. BUYER. If the gentleman would yield.

Mr. MORAN. I would love to yield.

Mr. BUYER. Obviously, it is worth looking at. I mean, no matter what the system is out there in government, whenever we can—whatever investments we also make to reduce costs and save money is smart business. You brought up something worth looking at. Thank you.

Mr. MORAN. Thank you, Mr. Buyer. Thank you, Mr. Thornberry, and thanks to the witnesses. I know you are trying to do as good a job as you can under the circumstances, and I do think that TRICARE, particularly TRICARE Prime, is going to get better as time goes on and that you are going to be able to automate more. I think that we all have the same objective. It just is frustrating to see this very high differential. You have explained why the differential exists, but it still is unacceptable in the long run and I trust that that gap will be narrowed because we are going to continue to be criticized for letting the system go on where the costs are so much higher than it costs HCFA. While we may understand that and may be sympathetic, it just lends itself to constant criticism and more and more GAO reports. But as you say, the process for automation is ongoing.

Why were you smiling there, Mr. Backhus?

Mr. BACKHUS. Dr. Sears got a chuckle out of more GAO reports. I agree.

Mr. MORAN. But do you not agree, until we narrow the gap, it is just easy pickings, and particularly for the Congress. But I know that the people involved are trying to do a good job and do the right thing. I do not have any sense that anybody is trying to rip off the system. And while we may have a lot of fraud, we have more fraud in HCFA, and I do not think fraud is the problem. I think we have a system that simply needs to be modernized and needs to be more subject to the information technology that is available. When you have small providers, you can understand why they just do not want to automate their system for a handful of claims. It does not make sense from their point of view.

It has been useful. Does our colleague, the ranking member of the full committee, want to have a final word of wisdom?

Mr. SPRATT. I just wanted to, if I could take a second and ask Mr. Meyer what has been your situation recently with respect to your own receivables from the Department of Defense.

Mr. MEYER. We have a problem there, Congressman Spratt. We are owed about $40 to $50 million in back payments.

Mr. SPRATT. At this point in time?

Mr. MEYER. Yes.

Mr. SPRATT. Is that high or low relative to the past?

Mr. MEYER. It is extremely high. We have two situations on two contracts where the government estimated claim volume came up way short of the actual claim volume and reasonable equitable adjustments were put forward. We have been working on them two to 3 years now. One of them did settle. The other one is still pending, and of that $40 million, most of it is wrapped up in that one settlement.

Mr. SPRATT. And was the fee that you, or the proposal that you made in the bidding for this contract predicated on a certain volume of claims processed?

Mr. MEYER. Yes, sir. In all five contracts, the government provided the claims volume estimate and said, bid your staffing and your dollars on your receiving this number of claims.

Mr. SPRATT. And what was their estimate, claims volume?

Mr. MEYER. It was different on each contract, but, for example, on the contract that is not resolved yet, the government estimate was five million claims per year.

Mr. SPRATT. And what did——

Mr. MEYER. In fact, we got seven-and-a-half million.

Mr. SPRATT. So it is off by 50 percent?

Mr. MEYER. Right.

Mr. SPRATT. Under by 50 percent.

Mr. MEYER. Correct.

Mr. SPRATT. And has this been a continual frustration, or has the basis for bidding improved as experience has gone on?

Mr. MEYER. The basis for the claims volume did improve in the last two contracts. In the last two contracts, the government actually asked us what we thought the volume would be and we jointly agreed on what the volume probably would be and, in fact, were right on the last two contracts. But it is the earlier contracts that still are not resolved that create the financial problem for us.

Mr. SPRATT. So does this indicate that in structuring this system, DOD underestimated what the administrative complexities and volume of claims processing was likely to be?

Mr. MEYER. Well, certainly the claims volume was underestimated.

Mr. SPRATT. What about, since you participated in this, the difficulties building the network? Do you think that the assumptions going into this were a bit too facile about how you would build a network?

Mr. MEYER. The problem that you have with this program with building the network is that the requirements are the same for 100 percent of the geographic area of this country, although the practice of medicine and distribution of the physicians is not the same. So the requirement for numbers of doctors in a network, for example, in Portsmouth, Virginia, where there is a high concentration

of military retirees and active duty military and their families, is the same as it is for Rock Hill, where there are not very many military retirees. So even though things are not the same, they are tried to force to make to look like the same.

Mr. SPRATT. Dr. Sears——

Mr. MEYER. Dr. Sears has done a great job working with us in trying to get that resolved, and Dr. Sears, to his credit, in the resolution of the REA has been the single person who has been trying to push to get the thing resolved more than anybody else. We wish we could get that kind of initiative underneath Dr. Sears.

Mr. SPRATT. How is it your largest contractor, you are $40 million in arrears on the payment of its account?

Dr. SEARS. I am pleased to be able to say that we are close to resolution of those REAs and the money for the prime that will be passed to the sub will be forthcoming.

Mr. SPRATT. Humana? You said the prime is—I may have misunderstood your——

Dr. SEARS. I did not say, but it is Humana.

Mr. SPRATT. Has this been a learning process for DOD? Do you think the Department underestimated the complexity of putting in place a national managed care network?

Dr. SEARS. There were many factors that—yes. As Mr. Meyer said, we are trying to put a uniform benefit in place across the country, and I worked actually for a contractor in California and it was very easy to build networks in San Diego and Los Angeles and San Francisco. It was very difficult to build networks in places like Monterey and to bring the same benefit and get the same advantages to the contractor and the government in those places.

We also, as you know, have been going through some very significant changes in health care and in the military health care system. The significant downsizing of military medical facilities, the conversions from hospitals to clinics, there are just a myriad of things that affected the—and the utilization, switching from a system where the beneficiary was the primary person who submitted claims to a system where the provider submits the claim in 97 percent of the cases. There were a number of factors that increased the number of claims over what the government projection was.

So yes, there were lessons learned and the example that was just used was one of those lessons, talking to the claims processor about what their anticipated numbers were and sitting down together and figuring out what a more likely number was and then going forward with that. That has been a feature of the program. This is a program that came up essentially in 1995 and is now worldwide and has had some growing pains, but tremendous progress has been made.

Mr. SPRATT. One final question. In our State with TRICARE, we have experienced—first of all, it took a while to fill out the network and now we are seeing repercussions to the rates of reimbursement of pay and there are pieces of the network that are sloughing off, providers pulling out, both hospitals and physicians. Is this a problem nationwide?

Dr. SEARS. It is a problem in some localities. As I say, where there are concentrations of providers, where there is some competition among providers, that is not an issue to us. In the commu-

nities where there are stand-alone providers or sole community hospitals, those sorts of things, that becomes more of an issue to us. The reimbursement rate, as you know, is at the Medicare level. CHAMPUS used to reimburse at higher levels than that. So we are experiencing some of the same things in terms of provider participation, actually, that Medicare is experiencing in terms of providers dropping out of the network.

Mr. SPRATT. So TRICARE rates equate to Medicare rates?

Dr. SEARS. We are required to have our rates at Medicare rates and that has been accomplished. There are a few of our rates that are somewhat higher, but those are for things that Medicare generally does not do, like deliveries and things of that nature. But yes, our rates are at the Medicare level.

Mr. SPRATT. Thank you very much.

Mr. THORNBERRY. Dr. Sears, have you made a request for money or some authorities to help improve the efficiency of claims processing that has gotten stopped while going up the chain?

Dr. SEARS. As you know, funding for the DHP is an issue and there are funding——

Mr. THORNBERRY. So you have made funding requests that basically get reduced before they get to the Congress?

Dr. SEARS. We do not have enough money to do all the things we want to do, yes, sir.

Mr. THORNBERRY. I think that was yes. OK.

I appreciate the testimony from all of you today. I think it certainly has been helpful. I am left a little bit with the feeling that we have a health care system that has some dissatisfaction among beneficiaries, some problems among providers, and to try to keep providers there, we are having to do things to try to be nice to them, paper filing in 2 weeks and the rest, that is more expensive and helps reduce care and puts further strain on the budget, which kind of gets to be a vicious circle. Hopefully, we can break out of that sort of thing.

I think at a minimum, we have got agreement that we can at least save $3 a claim if we get everything right, and certainly if there are—you were talking about the incentives and the things that Mr. Moran was talking about. If there are other authorities that any of you see would be helpful in getting us to save that $3 or $4 quicker, well, then please let us know.

If that is all, then we will call this hearing adjourned. Thank you all.

[Whereupon, at 12:20 p.m., the task force was adjourned.]

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